QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) 2018

ANNUAL EFFECTIVENESS AND EVALUATION 2017

Prepared By: MSHN Compliance Office- January 2018
Reviewed and Approved By: Quality Improvement Council – January 25, 2018
Reviewed By: MSHN Operations Council – February 12, 2018
Approved By: MSHN Board – March 6, 2018

Approved By: CMHA-CEI Board – March 22, 2018

TABLE OF CONTENTS

SECTION ONE – ANNUAL PLAN

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM 2017-2018

I. OVERVIEW

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid-State Health Network to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Health and Human Services as Region 5. The CMHSP Participants include Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network , Huron County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door and Tuscola Behavioral Health Systems. In January 2014, MSHN entered into its first contract with the State of Michigan for Medicaid funding, and entered into subcontracts with the CMHSPs in its region for the provision of Mental Health, Substance Use Disorder, and Developmental Disabilities services. The contract was expanded in 2014 to include an expanded Medicaid benefit, the Healthy Michigan Plan. The FY2015 contract expanded to include administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention. For FY2018, MSHN continues to sub-contract with CMHSPs within the region to provide Medicaid funded behavioral health services as well as directly contracting with Substance Use Disorder Providers within the region for the provision of all public funded SUD services.

MSHN monitors the overall quality and improvement of the PIHP. Responsibilities of the Quality Management Program are outlined in the Quality Assessment and Performance Improvement Plan (QAPIP). The scope of MSHN's QAPIP program is inclusive of all CMHSP Participants, the Substance Use Disorder Providers and their respective provider networks. Performance monitoring covers all important organizational functions and aspects of care and service delivery systems. Performance monitoring is accomplished through a combination of well-organized and documented retained, contracted and delegated activities. Where performance monitoring activities are contracted or delegated, MSHN assures monitoring of reliability and compliance.

II. PHILOSOPHICAL FRAMEWORK

The program design is based on the Continuous Quality Improvement (CQI) model of Shewhart, Deming and Juran. The key principles of the CQI model, as recently updated by Richard C. Hermann ("Developing a Quality Management System for Behavioral Health Care: The Cambridge Health Alliance Experience", November 2002), are:

- Health care is a series of processes in a system leading to outcomes;
- Quality problems can be seen as the result of defects in processes;
- Quality improvement efforts should draw on the knowledge and efforts of individuals

involved in these processes, working in teams;

- Quality improvement work is grounded in measurement, statistical analysis and scientific method;
- The focus of improvement efforts should be on the needs of the customer; and
- Improvement should concentrate on the highest priority problems.

Performance improvement is more narrowly defined as, "the continuous study and adaptation of health care organization's functions and processes to increase the probability of achieving desired outcomes, and to better meet the needs of clients and other users of services" (The Joint Commission, 2004-2005). MSHN employs the Plan-Do-Study-Act (PDSA) cycle, attributed to Walter Shewhart and promulgated by Dr. W. Edwards Deming, to guide its performance improvement tasks (Scholtes P. R., 1991).

Performance measurement is a critical component of the PDSA cycle. Measures widely used by MSHN for the ongoing evaluation of processes, and to identify how the region can improve the safety and quality of its operations, are as follows:

- A variety of qualitative and quantitative methods are used to collect data about performance;
- Well-established measures supported by national or statewide databases are used where feasible and appropriate to benchmark desired performance levels; if external data is not available, then local benchmarks are established;
- Statistically reliable and valid sampling, data collection and data analysis principles are followed as much as possible; and
- If the nature of the data being collected for a measure limits the organization's ability to control variability or subjectivity, the conclusions drawn based upon the data are likewise limited.

Data is used for decision making throughout the PIHP and its behavioral health contract providers through monitoring treatment outcomes, ensuring timeliness of processes, optimizing efficiency and maximizing productivity and utilizing key measures to manage risk, ensure safety, and track achievement of organizational strategies. MSHN's overall philosophy governing its local and regional quality management and performance improvement can be summarized as follows:

- Performance improvement is dynamic, system-wide and integrated;
- The input of a wide-range of stakeholders – board members, advisory councils, consumers, providers, employees, community agencies and other external entities, such as the Michigan Department of Health and Human Services, are critical to success;
- An organizational culture that supports reporting errors and system failures, as the means to improvement, and is important and encouraged;
- Improvements resulting from performance improvement must be communicated throughout the organization and sustained; and
- Leadership must establish priorities, be knowledgeable regarding system risk points, and act based upon sound data.

III. QUALITY AND COMPLIANCE

a) STRUCTURE (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018) (42 Code of Federal Regulations (CFR) 438.358, 2002)

The structure of the QAPIP allows each contracted behavioral health provider to establish and maintain its own unique arrangement for monitoring, evaluating, and improving quality. The MSHN Quality Improvement Council, under the direction of the Operations Council, is responsible for ensuring the effectiveness of the QAPIP. Process improvements will be assigned under the auspices of MSHN to an active PIHP council, committee, workgroup or task specific Process Improvement Team.

b) COMPONENTS (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018) (42 Code of Federal Regulations (CFR) 438.358, 2002)

MSHN will provide oversight and monitoring of all members of its contracted behavioral health network in compliance with applicable regulatory guidance. For the purposes of the Quality Management functions germane to successful PIHP operations, the following core elements shall be delegated to the Community Mental Health Services Programs and SUD Providers within the region:

- Implementation of Compliance Monitoring activities as outlined in the MSHN Corporate Compliance Plan
- Develop and Implementation of Quality Improvement Program in accordance with PIHP Quality Assessment and Performance Improvement Plan
- Staff Oversight and Education
- Conducting Research (if applicable)

MSHN will provide guidance on standards, requirements and regulations from the MDHHS, the External Quality Review, the Balanced Budget Act, and/or other authority that directly or indirectly affects MSHN PIHP operations.

MSHN will retain responsibility for developing, maintaining, and evaluating an annual QAPIP plan and report in collaboration with its CMHSP Participants and Substance Use Disorder Providers. MSHN will comply with 42 CFR Program Integrity Requirements, including designating a PIHP Compliance Officer. Assurances for uniformity and reciprocity are as established in MSHN provider network policies and procedures (Region 5 PIHP 2013 Application for Proposal for Specialty Prepaid Inpatient Health Plans, 2013, p. 2.7.3).

c) GOVERNANCE (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018)

<u>Board of Directors</u>
The MSHN's Board of Directors employs the Chief Executive Officer (CEO), sets policy related to quality management, and approves the PIHP's QAPIP, including quality management priorities as

identified in this plan. The QAPIP Plan is evaluated and updated annually, or as needed, by the MSHN Quality Improvement Council.

Through the Operations Council, Substance Use Disorder Oversight Policy Board and MSHN CEO, the MSHN's Board of Directors receives an Annual Quality Assessment and Performance Improvement Report evaluating the effectiveness of the quality management program, and recommending priorities for improvement initiatives for the next year. The report describes quality management activities, performance improvement projects, and actions taken and the result of those actions. After review of the Annual Quality Assessment and Performance Improvement Report, through the MSHN CEO the Board of Directors submits the report to the Michigan Department of Health and Human Services (MDHHS).

Chief Executive Officer

MSHN's CEO is hired/appointed by the PIHP Board and is the designated senior official with responsibility for ensuring implementation of the regional QAPIP. The MSHN CEO has designated the Director of Compliance, Customer Service and Quality as the chair of the MSHN Quality Improvement Council. In this capacity, the Director of Compliance, Customer Service and Quality is responsible for the development, review and evaluation of the Quality Assessment and Performance Improvement Plan and Program in collaboration with the MSHN Quality Improvement Council.

The MSHN CEO allocates adequate resources for the quality management program and is responsible for linking the strategic planning and operational functions of the organization with the quality management functions. The CEO assures coordination occurs among members of the Operations Council to maintain quality and consumer safety. Additionally, the CEO is committed to the goals of the quality improvement plan and to creating an environment that is conducive to the success of quality improvement efforts, ensuring affiliation involvement, removing barriers to positive outcomes, and monitoring results of the quality improvement program across the PIHP. The CEO reports to the PIHP Board of Directors recommending policies and/or procedures for action and approval. The CEO is responsible for managing contractual relationships with the CMHSP Participants and Substance Use Disorder Providers and for issuing formal communications to the CMHSP Participants/SUD Providers regarding performance that does not meet contractual requirements or thresholds. Similarly, the CEO is responsible for assuring ongoing monitoring and compliance with its MDHHS contract including provision of performance improvement plans as required.

Medical Director

Through consultative council involvement, the MSHN Medical Director provides leadership related to clinical service quality and service utilization standards and trends. The Medical Director is an ad hoc member of the MSHN Quality Improvement Council and demonstrates an ongoing commitment to quality improvement; participating on committees and work teams as needed, reviewing quality improvement reports, sentinel events, and critical incidents; and assisting in establishing clinical outcomes for the PIHP.

The MSHN Medical Director consults with MSHN staff regarding service utilization and eligibility decisions and is available to provide input as required for the regional QAPIP. As necessary, consultation occurs between the MSHN Medical Director and CMHSP Participant and Substance Use Disorder Medical Directors.

CMHSP Participants/SUD Providers

A quality representative from each CMHSP is appointed by the CMHSP CEO to participate in the MSHN Quality Improvement Council. Substance Use Disorders services is represented on the Council by MSHN SUD Staff. CMHSP Participant/SUD Provider staff have the opportunity to participate in and to support the QAPIP through organization wide performance improvement initiatives. In general, the CMHSP Participant/SUD Provider staff's role in the PIHP's performance improvement program includes:

- Participating in the data collection related to performance measures/indicators at the organizational or provider level;
- Identifying organization-wide opportunities for improvement;
- Having representation on organization-wide standing councils, committees and work groups, and
- Reporting clinical care errors, informing consumers of risks, and making suggestions to improve the safety of consumers.

Councils and Committees

MSHN has Councils and Committees that are responsible for providing recommendations and reviewing regional policy's regarding related managed care operational decisions. Each council/committee develops and annually reviews and approves a charter that identifies the following; Purpose, Decision Making Context and Scope, Defined Goals, Monitoring, Reporting and Accountability, Membership, Roles and Responsibilities Meeting Frequency, Member Conduct and Rules, Past Year's Accomplishments and Upcoming Goals **(Section Two)**. The Operations Council approves all council/committee charters. Each council/committee guides the Operations Council who advises the MSHN CEO. These recommendations are considered by the Operations Council on the basis of obtaining a consensus or simple majority vote of the twelve CMHSPs. Any issues remaining unresolved after Operations Council consideration will be subject to a vote with the minority position being communicated to the MSHN Board. The MSHN CEO retains authority for final decisions or for recommending action to the MSHN Board.

Among other duties, these councils/committees identify, receive, and respond on a regular basis to opportunities and recommendations for system improvements arising from the MSHN Quality Assessment and Performance Improvement Program and reports annually on the progress of accomplishments and goals **(Section Three**).

SUD Oversight Policy Board

Pursuant to section 287 95) of Public Act 500 of 2012, MSHN established a Substance Use Disorder Oversight Policy Board (OPB) through a contractual agreement with and membership appointed by each of the twenty-one counties served. The SUD-OPB is responsible to approve an annual budget inclusive of local funds for treatment and prevention of substance use disorders; and serves to advise the MSHN Board on other areas of SUD strategic priority, local community needs, and performance improvement opportunities.

Practitioners- SUD-PAW Advisory Workgroup

PAW is charged with serving in an advisory capacity to MSHN to offer input regarding SUD policies, procedures, strategic planning, monitoring and oversight processes, to assist MSHN with establishing and pursuing state and federal legislative, policy and regulatory goals, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served.

Recipients (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018)
MSHN continues the legacy of its founding CMHSP Participants by promoting and encouraging active consumer involvement and participation within the PIHP, the respective CMHSPs and their local communities. MSHN has formed a Regional Consumer Advisory Council that will be the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports requirements in the region.

Recipients of services participate in the QAPIP through involvement on workgroups, process improvement teams, advisory boards and Quality Improvement (QI) Councils at the local and regional level. Recipients provide input into policy and program development, performance indicator monitoring, affiliation activities/direction, self-determination efforts, QI projects, satisfaction findings, consumer advocacy, local access and service delivery, and consumer/family education, etc.
In addition to the participation of recipients of services in quality improvement activities, MSHN and the CMHSP Participants/ SUD Providers strive to involve other stakeholders including but not limited to providers, family members, community members, and other service agencies whenever possible and appropriate. Opportunities for stakeholder participation include the PIHP governing body membership; Consumer Advisory activities at the local, regional and state levels; completion of satisfaction surveys; participation on quality improvement work teams or monitoring committees; and focus group participation.

Stakeholder input will be utilized in the planning, program development, and evaluation of services, policy development, and improvement in service delivery processes.

d) COMMUNICATION OF PROCESS AND OUTCOMES (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018)

The Quality Improvement Council (QIC) is responsible for monitoring and reviewing performance measurement activities. MSHN, in addition to the CMHSPs Participants/SUD Providers, identify and monitor opportunities for process and outcome improvements.

For any performance measure that falls below regulatory standards and/or established targets, plans of correction are required. After QIC meetings, reports are communicated through regular reporting via Councils, Committees, and the Board of Directors and Consumer Advisory Council meetings. Status of key performance indicators, consumer satisfaction survey results, and performance improvement (PI) projects are reported to consumers and stakeholders, as dictated by the data collection cycle. The Board of Directors receives an annual report on the status of organizational performance. Final performance and quality reports are made available to stakeholders and the general public as requested and through routine website updates.

MSHN is responsible for reporting the status of regional PI projects and verification of Medicaid services to MDHHS. These reports summarize regional activities and achievements, and include interventions resulting from data analysis.

e) MEDICAID EVENT VERIFICATION (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018and Medicaid Event Verification Technical Requirement-Attachment P.6.4.1)

MSHN has established a written policy and procedure for conducting site reviews to provide monitoring and oversight of the Medicaid and Healthy Michigan funded claims/encounters submitted within the Provider Network. MSHN verifies the delivery of services billed to Medicaid and Healthy Michigan in accordance with federal regulations and the state technical requirement.

Medicaid Event Verification for Medicaid and Healthy Michigan Plan includes testing of data elements from the individual claims/encounters to ensure the proper code is used for billing; the eligibility of the beneficiary on the date of service; that the service provided is part of the beneficiaries individualized plan of service (and provided in the authorized amount, scope and duration); services were provided by a qualified individual; the amount billed/paid does not exceed the contract amount; and appropriate modifiers were used following the HCPCS guidelines.

Data collected through the Medicaid Event Verification process is aggregated, analyzed and reported for review at the QI Council meetings, and opportunities for improvements at the local or regional level are identified. The findings from this process, and any follow up needed, are reported annually to MDHHS through the Medicaid Event Verification Service Methodology Report. All CMHSP Participants/SUD Providers of MSHN have implemented the generation of a summary of Explanations of Benefits in accordance with the MDHHS Specialty Mental Health Services Program contract. This will provide an additional step to ensure that consumers are aware of service activity billed to their insurance.

f) QUANTITATIVE AND QUALITATIVE ASSESSMENT OF MEMBER EXPERIENCES (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018)

The opinions of consumers, their families and other stakeholders are essential to identify ways to improve processes and outcomes. Surveys and focus groups are an effective means to obtain input on both qualitative and quantitative experiences. Consumers receiving services funded by the PIHP are surveyed by MSHN at least annually using standardized survey tools . The tools vary in accordance with service population needs, and address quality, availability, and accessibility of care. Focus groups are conducted as needed to obtain input on specific issues. Consumers may also be queried by the CMHSP Participants/SUD Providers regarding the degree of satisfaction via periodic reviews of the status of their person-centered plans, as well as during discharge planning for the cessation or transition of services. Other stakeholders provide input through a survey process. Regional benchmarks are used for comparison.

The aggregated results of the surveys are collected, analyzed and reported by MSHN in collaboration with the QI Council and Regional Consumer Advisory Council, who identify strengths, areas for improvement and make recommendations for action and follow up as appropriate. The data is used to identify best practices, demonstrate improvements, or identify problem areas. The QI Council determines appropriate action for improvements, and the resulting findings are incorporated into program improvement action plans. At the CMHSP Participant/SUD Provider level, actions is taken on survey results of individual cases, as appropriate, to identify and investigate sources of

dissatisfaction and follow-up.

Survey results are included in the annual PIHP QAPIP Report and presented to the MSHN governing body, accessible on the MSHN website, the Operations Council, Regional Consumer Advisory Council, CMHSP Participants and SUD Providers. Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

I. PROVIDER NETWORK

a) CREDENTIALING, PROVIDER QUALIFICATION AND SELECTION (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018)

In compliance with MDHHS's Credentialing and Re-Credentialing Processes (FY16 Attachment P7.1.1,), MSHN has established written policy and procedures for ensuring appropriate credentialing and re- credentialing of the provider network. Whether directly implemented, delegated or contracted, MSHN shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. MSHN written policies and procedures also ensure that non-licensed providers of care or support are qualified to perform their jobs.

Credentialing, privileging, primary source verification and qualification of staff who are employees of MSHN, or under contract to the PIHP, are the responsibility of MSHN. Credentialing, privileging, primary source verification and qualification of CMHSP Participant/SUD Provider staff and their contractors is delegated to the CMHSP Participants/SUD Providers. MSHN monitors CMHSP Participant SUD Provider compliance with federal, state, and local regulations and requirements annually through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies.

MSHN policies and procedures are established to address the selection, orientation and training of directly employed or contracted staff. PIHP employees receive annual reviews of performance and competency. Individual competency issues are addressed through staff development plans. MSHN is responsible for ensuring that each provider, employed and contracted, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements, including relevant work experience and education, and cultural competence. The CMHSP Participants/SUD Providers are likewise responsible for the selection, orientation, training and evaluation of the performance and competency of their own staff and subcontractors.

b) PROVIDER MONITORING (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018)

MSHN uses a standard written contract to define its relationship with CMHSP Participants/SUD Providers that stipulated required compliance with all federal and state requirements, including those defined in the Balance Budget Act (BBA), the Medicaid Provider Manual, and the master contract between the PIHP and MDHHS.

Each CMHSP Participant/SUD Provider is contractually required to ensure that all eligible recipients have access to all services required by the master contract between the PIHP and MDHHS, by either direct service provision or the management of a qualified and competent provider panel. Each

CMHSP Participant/SUD Provider is also contractually required to maintain written subcontracts with all organizations or practitioners on its provider panel. These subcontracts shall require compliance with all standards contained in the BBA, the Medicaid Provider Manual, and the Master Contract between the PIHP and the MDHHS.

Each CMHSP Participant/SUD Provider is required to document annual monitoring of each provider subcontractor as required by the BBA and MDHHS. The monitoring structure shall include provisions for requiring corrective action or imposing sanctions, up to and including contract termination if the contractor's performance is inadequate. MSHN continually works to assure that the CMHSP Participants/SUD Provider maintain common policies, review common standards, and evaluate common outcomes. MSHN monitors compliance with federal and state regulations annually through a process that includes any combination of desk review, site review verification activities, and/or other appropriate oversight and compliance enforcement strategies as necessary. MSHN has developed a process for coordinating and/or sharing annual contractor monitoring reviews to avoid duplication of efforts and to reduce the burden on shared contractors. CMHSPs Participants/SUD Providers that are unable to demonstrate acceptable performance are required to provide corrective action, will be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN, up to and including contract termination.

c) EVENT MONITORING AND REPORTING (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018)

MSHN submits and/or reports required events to MDHHS such as critical incidents (including sentinel events), and events requiring immediate notification as specified in the Medicaid Managed Specialty Supports Services contract within the timelines required by MDHHS.

MSHN delegates the responsibility of the process for review and follow-up of sentinel events, critical incidents, and other events that put people at risk of harm to its CMHSP Participants and SUD Providers. Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrants PIHP review. Subsets of these events, adverse events, will qualify as "reportable events" according to the MDHHS Event Reporting System. These include MDHHS defined critical incidents, risk events, and sentinel events. MSHN also ensures that each CMHSP Participant/SUD Provider has a system in place to monitor these events, utilizing staff with appropriate credentials for the scope of care, and within the required timeframes. MSHN will ensure that the CMHSP and SUD Provider have taken appropriate action to ensure that any immediate safety issues have been addressed.

MSHN provides oversight and monitoring of the CMHSP Participant/SUD Provider processes for reporting sentinel events, critical events, and risk events as defined in the Medicaid Managed Specialty Supports and Service Concurrent 1915 (b)/(c) Waiver Program FY16 Attachment P7.9.1 and/or events requiring immediate notification to MDHHS. In addition, MSHN oversees the CMHSP Participant/SUD Provider process for quality improvement efforts including analysis of all events and other risk factors, identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction. The goal of reviewing these events is to focus the attention of the CMHSP Participant/SUD Provider on potential underlying causes of events so that changes can be made in systems or processes in order to reduce the probability of such events in the future. Following completion of a root cause analysis, or investigation, the CMHSP

will develop and implement either a plan of action or an intervention to prevent further occurrence or recurrence of the adverse event, or documentation of the rationale for not pursuing an intervention.

The plan shall address the staff and/or program/committee responsible for implementation and oversight, time lines, and strategies for measuring the effectiveness of the action

II. CLINICAL

a) OVERSIGHT OF "VULNERABLE PEOPLE" (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018)

MSHN assures the health and welfare of the region's service recipients by establishing standards consistent with MDHHS contract requirements and reporting guidelines for all CMHSPs and subcontracted providers. Each CMHSP Participant/SUD Provider shall have processes for addressing and monitoring the health, safety and welfare of all individuals served.

MSHN ensures that services are consistently provided in a manner that considers the health, safety, and welfare of consumers, family, providers and other stakeholders. When health and safety, and/or welfare concerns are identified, those concerns will be acknowledged and actions taken as appropriate.

MSHN monitors population health through data analytics software to identify adverse utilization patterns and to reduce health disparities.

MSHN monitors compliance with federal and state regulations annually through a process that may include any combination of desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies as necessary. CMHSP organizations and SUD Providers that are unable to demonstrate acceptable performance may be subject to additional PIHP oversight and intervention.

b) CULTURAL COMPETENCY

MSHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

Competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment and economic factors, etc.

III. UTLIZATION MAGAMENT

a) UTILIZATION MANAGEMENT PLAN (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

MSHN ensures access to publicly funded behavioral health services in accordance with the Michigan Department of Health and Human Services contracts and relevant Medicaid Provider Manual and Mental Health Code requirements.

MSHN directly or through delegation of function to the CMHSP Participants/SUD Providers acting on its behalf, is responsible for the overall network's utilization management (UM) system. Each CMHSP Participant/SUD Provider is accountable for carrying out delegated UM functions and/or activity relative to the people they serve through directly operated or contracted services.

Initial approval or denial of requested services is delegated to CMHSP Participants/SUD Providers, including the initial screening and authorization of psychiatric inpatient services, partial hospitalization, and initial and ongoing authorization of services for individuals receiving community services. All service authorizations are based on medical necessity decisions that establish the appropriate eligibility relative to the identified services to be delivered. Communication with individuals regarding UM decisions, including adverse benefit determination notice, right to second opinion, and grievance and appeals will be included in this delegated function.

Utilization review functions are delegated to CMHSP Participants/SUD Providers in accordance with MSHN policies, protocols and standards. This includes local-level prospective, concurrent and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, and standards and protocols. A Regional Utilization Management Committee comprised of each CMHSP Participant assists in the development of standards and reviews/analyzes region-wide utilization activity and trends.

MSHN ensures that screening tools and admission criteria are based on eligibility criteria established in contract and policy and are reliably and uniformly administered. MSHN policies are designed to integrate system review components that include PIHP contract requirements and the CMHSP Participant's/SUD Provider roles and responsibilities concerning utilization management, quality assurance, and improvement issues.

MSHN has established criteria for determining medical necessity, and the information sources and processes that are used to review and approve provision of services.

MSHN has mechanisms to identify and correct under-and over-utilization of services as well as procedures for conducting prospective, concurrent, and retrospective reviews. MSHN ensures through policy and monitoring of the CMHSP Participants/SUD Providers that qualified health professionals supervise review decisions and decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to provide treatment. Through policy and monitoring of CMHSP Participants/SUD Providers, MSHN shall ensure that reasons for treatment decisions are clearly documented and available to persons served; information regarding all available appeals processes and assistance through customer services is communicated to the consumer; and notification requirements are adhered to in accordance with the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services.

b) AUTISM BENEFIT (Medicaid Managed Specialty Supports and Services Early and Periodic Screening, Diagnosis and treatment (EPSDT) State plan Home and Community-Based Services Administration and Operation)

MSHN oversees provision of the autism benefit within its region. MSHN delegates to the CMHSPs

the application of the policies, rules and regulations as established. MSHN assures that it maintains accountability for the performance of the operational, contractual, and local entity efforts in implementation of the autism program. MSHN tracks program compliance through the MSHN quality improvement Strategy and performance measures required by the benefit plan. MSHN collects data on the performance of the autism benefit consistent with the EPSDT state plan and reviews this data monthly to quarterly with the CMHSPs within its region and calls for ongoing system and consumer-level improvements. This data is shared with the MDHHS as required, for the purpose of reporting individual-level and systemic-level CMHSP quality improvement efforts.

Autism Benefit Review

Re-evaluations shall address the ongoing eligibility of the autism benefit participants and are updated annually. All providers of ABA services shall meet credentialing standards as identified in the EPSDT benefit and Michigan Medicaid Manual to perform their function.

c) BEHAVIOR TREATMENT (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program 2018 Attachment P1.4.1, Technical Requirement for Behavioral Treatment Plan Review Committees-2012)

MSHN delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee, including the evaluation of the effectiveness of the Behavior Treatment Committee by stakeholders. Data is collected and reviewed quarterly by the CMHSP where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. Only techniques approved by the Technical Requirement for Behavior Treatment Plan, agreed to by the individual or his/her guardian during the person-centered planning, and supported by current peer- reviewed psychological and psychiatric literature may be used. MSHN also receives CMHSP behavior treatment data regarding consumers on the habilitation supports waiver. This data has been piloted and tracked in the MSHN region and provides sub-assurances within participant safeguards that require additional oversight & monitoring by the Michigan Department of Health and Human Services (MDHHS) for habilitation supports waiver enrollees around use of intrusive and/or restrictive techniques for behavioral control. By asking the behavior treatment committees to track these data, it provides important oversight to the protection and safeguard of vulnerable individuals. This data has been shared on a quarterly basis with MDHHS, but further guidance is being sought as to whether this expectation will be ongoing. CMHSP data is reviewed as part of the CMHSP Quality Program and reported to the MSHN QIC at a defined frequency. MSHN analyzes the data on a quarterly basis to address any trends and/or opportunities for quality improvements. MSHN also uses this data to provide oversight via the annual site review process at each of the CMHSPs. Data shall include numbers of interventions and length of time the interventions were used per person.

d) PRACTICE GUIDELINES (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018)

MSHN supports CMHSP Participants local implementation of practice guidelines based on the Medicaid Provider Manual, the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program, and Evidence Based Practice models. The process for determining what practice guidelines were utilized is a locally driven process in collaboration with the MSHN

Councils and Committees. Practice guidelines are chosen to meet the needs of persons served in the local community and to ensure that everyone receives the most efficacious services. Practice guidelines as stated above are reviewed and updated annually or as needed, and are disseminated to appropriate providers.

e) PERFORMANCE MEASUREMENT

General Methods (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018)

The Quality Assessment and Performance Improvement Program encourages the use of objective and systematic forms of measurement. Each established measure should align with MSHN's goals and priorities and needs to have clear expectations, promote transparency, and be accountable through ongoing monitoring.

Measures can be clinical and non-clinical. Desired performance ranges and/or external benchmarks are included when known. MSHN is responsible for the oversight and monitoring of the performance of the PIHP including data collection, documentation, and data reporting processes to ensure compliance with PIHP contract requirements and State and Federal processes and requirements.

Establishing Performance Measures:

The measures established should reflect the organizational priorities, have a baseline measurement when possible, have an established re-measurement frequency (at least annually) and should be actionable and likely to yield credible and reliable data over time.

Information is the critical product of performance measurement that facilitates clinical decision-making, organizational decision-making (e.g., strategic planning and day-to-day operations), performance improvement, and priorities for risk reduction. Data must be systematically aggregated and analyzed to become actionable information.

Data Collection and Setting Performance Targets:

Data is aggregated at a frequency appropriate to the process or activity being studied. Statistical testing and analysis is then used as appropriate to analyze and display the aggregated data. PIHP data is analyzed over time to identify patterns and trends, and compared to desired performance levels, including externally derived benchmarks when available.

When a performance measure has an established performance target set through contract requirements, then that target will be utilized to measure performance. If there is no set performance target, baseline data should be considered prior to setting a target. Baseline data is a snapshot of the performance of a process or outcome that is considered normal, average, or typical over a period of time. The baseline may already be established through historical data, or may still need to be collected. If baseline data is not available for an established measure, then the measure should be implemented for a period of time (typically up to one year) prior to establishing performance targets. When collecting baseline data, it is important to establish a well documented, standardized and accurate method of collecting the data and set ongoing frequencies to review the

data (monthly, quarterly, etc.)

Once the baseline has been established for a measure, it can be determined if a performance target should be established or not. If the baseline data is at or above the state and national benchmarks, when available, and deemed within acceptable standards, it is up to the monitoring committee or team to determine if a performance measure should be established or if the measure should just continue to be monitored for variances in the baseline data. If the baseline data is below the state and national benchmarks, when available, then a performance target should be established that is at, or greater than, the state and national average.

When establishing performance targets, the following should be considered (as defined in the Health Resources and Service Administration (HRSA) Quality Tool Kit):

a) *Minimum or Acceptable Level.* Performance standards can be considered "minimum" or "acceptable" levels of success.
b) *Challenge Level*. This level defines a goal toward which efforts are aimed. Performance results below this level are acceptable because the level is a challenge that is not expected to be achieved right away.
c) *Better Than Before.* The performance measurement process is comparative from measurement period to measurement period. Success is defined as performance better than the last period of measurement. This definition comes out of the continuous quality improvement (CQI) perspective.

Targets may be defined in several ways including the following:

a) Defining a set target percentage for achievement – such as 75% will meet the outcome being measured
b) Defining a percentage change for achievement – such as the percentage will increase by 10% over an established length of time

Data Analysis:
The data should be reviewed at the established intervals and analyzed for undesirable patterns, trends, or variations in performance. In some instances, further data collection and analysis may be necessary to isolate the causes of poor performance or excessive variability.

The appropriate council, committee, or workgroup, in collaboration with the QIC, will prepare a written analysis of the data, citing trends and patterns, including recommendations for further investigation, data collection improvements to resolve data validity concerns, and/or system improvements.

Region wide quality improvement efforts will be developed based on the patterns and trends identified and will be reviewed for effectiveness at established intervals within the appropriate MSHN council, committees, workgroups, etc. In some instances, provider level corrective action may be necessary in addition to, or in lieu of, region wide improvement efforts.

<u>Performance Improvement Action Steps:</u>
Process improvements are achieved by taking action based upon data collected and analyzed through performance measurement activities. Actions taken are implemented systematically to insure any improvements achieved are truly associated with the action. Adhering to the following steps promotes

process integrity:

- Develop a step by step action plan;
- Limit the number of variables impacted;
- Implement the action plan, preferably on a small or pilot scale initially, and
- Collect data to check for expected results.

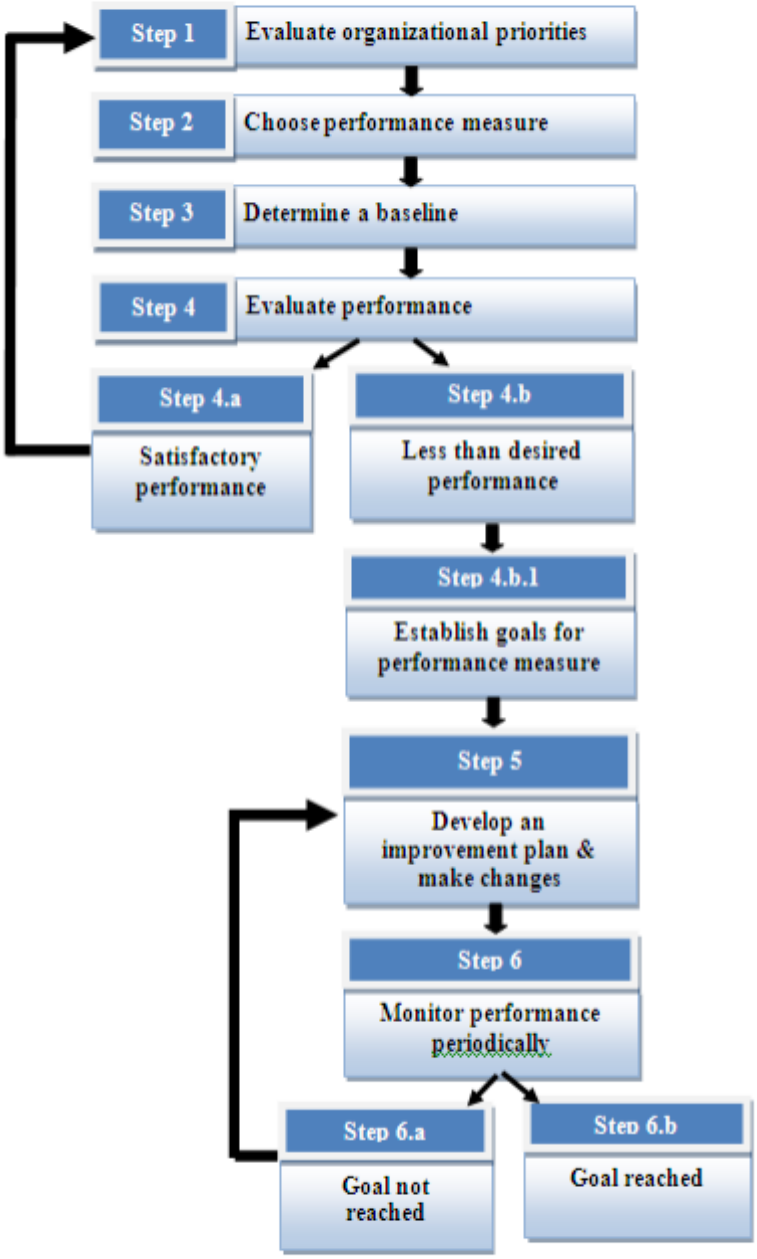
The process of measurement, data collection, data analysis and action planning is repeated until the desired level of performance/improvement is achieved. Sustained improvement is sought for a reasonable period of time (such as one year) before the measure is discontinued. When sustained improvement is achieved, measures move into a maintenance modality, with a periodic reassessment of performance to insure the desired level of quality is being maintained, as appropriate, unless the measure(s) mandated by external entities such as the MDHHS require further measurement and analysis.

When the established minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a corrective action plan the includes the following:

- Causal factors that caused the variance (directly and/or indirectly)
- Interventions that will be implemented to correct the variance
- Timelines for when the action will be fully implemented
- How the interventions will be monitored
- Any other actions that will be taken to correct undesirable variation

The appropriate MSHN staff, council, committee, workgroup, etc. will monitor the implementation and effectiveness of the plans of correction. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

Process Map of Performance Management Pathway (defined by HRSA)


Step 1
Evaluate organizational priorities
Step 2
Choose performance measure
Step 3
Determine a baseline
Step 4
Evaluate performance
Step 4.a
Satisfactory performance
Step 4.b
Less than desired performance
Step 4.b.1
Establish goals for performance measure
Step 5
Develop an improvement plan & make changes
Step 6
Monitor performance periodically
Step 6.a
Goal not reached
Step 6.b
Goal reached

Performance Indicators

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in the area of access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that it's CMHSP Participants and Substance Use Disorder Providers are measuring performance through the use of standardized performance indicators.

When minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a form identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. The form will be reviewed by the MSHN CO and the MSHN contractor to ensure sufficient corrective action planning. Regional trends will be identified and discussed at the QIC for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

Performance Improvement Projects

MDHHS requires the PIHP to complete a minimum of two PI projects per year. One of the two is chosen by the department based on Michigan's Quality Improvement Council recommendations. This project is subject to validation by the external quality review (EQR) organization and requires the use of the EQR's form. The second or additional PI project(s) is chosen by the PIHP based on the needs of the population served, previous measurement and analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided. The QIC approves the performance improvement projects and presents to relevant committees and councils for collaboration.

Data collected through the performance improvement projects are aggregated, analyzed and reported at the QIC meeting. The population from which a sample is pulled, the data collection timeframe, the data collection tool, and the data source are defined for each measure, whether local or regional. A description of Project/Study is written for each measure which documents why the project was chosen and identifies the data that was used to determine there was a problem and who is affected by the problem. It incorporates the use of valid standardized data collection tools and consistent data collection techniques. Each data collection description delineates strategies to minimize inter-rater reliability concerns and maximize data validity. Provisions for primary source verification of data and maintenance of documentation are also addressed in the description of the project/study. If sampling is used, appropriate sampling techniques are required to achieve a statistically reliable confidence level. The default confidence level for MSHN performance measurement activity is a 95% confidence level with a 5% margin of error.

Identification of Quality Concerns and Opportunities for Improvement

Measures are selected consistent with established MSHN QAPIP priorities, as specified in this plan. The PIHP quality management program uses a variety of means to identify system issues and opportunities for improvement.

Prioritizing Measures (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

Measures are chosen based upon selection and prioritization of projects, data collection, and analysis of data, and will be based on the following three factors:

Focus Area: Clinical (prevention or care of acute or chronic conditions; high volume or high risk services; continuity and coordination of care), or Non-Clinical (availability, accessibility, and cultural competency or services; interpersonal aspects of care; appeals, grievances, and other complaints.)

Impact: The effect on a significant portion of consumers served with potentially significant effect on quality of care, services, or satisfaction.

Compliance: Adherence to law, regulatory, or accreditation requirements; relevancy to stakeholders due to the prevalence of a condition, the need for a service, access to services, complaints, satisfaction, demographics, health risks or the interests of stakeholders as determined through qualitative and quantitative assessment.

(2018). *Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program.*

(2018). *Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1*

(2013). *Region 5 PIHP 2013 Application for Proposal for Specialty Prepaid Inpatient Health Plans.*

(2004-2005). The Joint Commission. *Comprehensive Accreditation Manual for Behavioral Health Care.*

(May 13, 2011). *Michigan Department of Community Health (MDCH)/Prepaid Inpatient Health Plan (PIHP) Event Reporting v1.1, Data Exchange Workgroup-CIO-Forum.*

(2018). *Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program 2015 Attachment P1.4.1, Technical Requirement for Behavioral Treatment Plan Review Committees-, Revision FY'12.*

(November 2002). "Developing a Quality Management System for Behavioral Health Care: The Cambridge Health Alliance Experience". *Harvard Review of Psychiatry*.

(1991). Scholtes, P. R. In *The Team Handbook* (pp. 5-31). Madison, WI: Joiner Associates, Inc.

SECTION TWO – ANNUAL REPORTS

I. Council FY17 Accomplishments & FY18 Goals

ANNUAL REPORT

TEAM NAME: Operations Council

TEAM LEADER: Joseph P. Sedlock, MSHN Chief Executive Officer

REPORT PERIOD COVERED: 10.1.16 – 9.30.17

Purpose of the Operations Council: The MSHN Board has created the Operations Council (OC) to advise the Pre-Paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) concerning the operations of the Entity. Respecting that the needs of individuals served and communities vary across the region, it will inform, advise, and work with the CEO to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that are accountable to the entity board, funders and the citizens who make our work possible.

Responsibilities and Duties: The responsibilities and duties of the OC shall include the following:

- Advise the MSHN CEO in the development of the long term plans of MSHN;
- Advise the MSHN CEO in establishing priorities for the Board's consideration;
- Make recommendations to the MSHN CEO on policy and fiscal matters;
- Review recommendations from Finance, Quality Improvement, Information Technology Councils and other Councils/Committees as assigned;
- Assure policies and practices are operational, effective, efficient and in compliance with applicable contracting requirements and regulatory standards; and
- Undertake such other duties as may be delegated by the Entity Board.

Defined Goals, Monitoring, Reporting and Accountability

The OC shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Expanded local service access (penetration rates),
- Fiscal accountability,
- Compliance, and
- Improved health outcomes/satisfaction.

Additionally, the OC seeks to assess and achieve the following secondary goals:

- Retained and delegated function contracts achieved defined results, and are carried out in a manner that achieves consistency, standardization and cost-effectiveness

- Collaborative relationships are retained (Evaluation of principles and values),
- Board satisfaction with OC advisory role,
- Staff perception and sense of knowing what is going on,
- Efficiencies are realized through standardization and performance improvement, and
- Benefits are realized through our collective strength.

OC Annual Evaluation Process

a. Past Year's Accomplishments: The OC had 12 meetings during the reporting period. The role of the Operations Council is in part to advise MSHN, oversee operations, and promote effective and efficient operations. The following accomplishments of particular importance are noted:
    - Planned for future collaboration, implemented and led collaboration activities between MSHN, Medicaid Health Plans and CMHSPs.
    - Completed Annual Policy Review Processes.
    - Retained commitment to core values and collective focus despite external threats associated with Governor Snyder's Budget Proposal, in particular sec. 298.
    - Facilitated CMHSP partner dialog on administrative and clinical efficiencies including short- and long-term financial management strategies.
    - SIS (Supports Intensity Scale) Integration initial implementation cost was approved and continues to move forward.
    - Approval of Regional Consumer Advisory Council Annual Charter was given.
    - Legislative and Public Policy Advocacy policy was approved.
    - Approved protocols and training plan by ZTS (Zenith Technology Solutions) for Care Coordination Lite Licenses, which were obtained by MSHN for all CHMSPs. License to be used for Care Coordination with ICDP (Integrated Care Delivery Platform).
    - Support provided for continued use of PMTO (Parent Management Training- Oregon model) Grant.
    - Approval of Utilization Management Plan.
    - Board approved VA contact with Right Door. Kevin Thompson will be the regional Veteran Navigator, he will be working to define regional process and procedures.
    - Support to move ahead with Hospitalization for Mental Illness Measure Reporting.
    - Approved and implemented Regional Fiscal Intermediary standardized contract and regional provider performance monitoring systems
    - Approved Healthy Michigan financing/smoothing plan/procedure
    - Approved MSHN Regional Measurement Portfolio
    - MSHN Compliance Plan for FY17-FY18 was reviewed and approved.
    - Creation and support given for Standard Consent Form.
    - Approval of FY17 QAPIP (Quality Assessment Performance Improvement Program) and FY16 QAPIP Effectiveness Plan.
    - FY18 regional Inpatient Contract Standard accepted; regional monitoring system, including recipient rights components, under consideration.
    - Supported regional response to the request of a CMHSP Participant for a cash advance and related actions to mitigate regional risk.
    - Approved Consent to Share Information Policy.
    - Discussed and shared budget reduction strategies as well as reducing debt and long-term debt strategies.

- MSHN Provider Network Adequacy Assessment was approved to proceed.
- Approval of Cash Flows/Autism Payments/ Cost Settlements.
- Direct Care Worker Wage increase was passed in the budget signing of 298.
- Ongoing discussion of MCIS (Managed Care Information System) and remain updated on procurement of system.
- Adopted several clinical protocols
- Approval of Transfer of County to CMHSP Care Responsibility Policy.
- Regional Narcan/ Naloxone project started. Project will allow for a region wide standard of accessibility and administration.
- Continued support for enhanced local access for citizens with substance use concerns through SUD provider network partnerships with CMHSPs on a 24/7/365 basis.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2018

- Assist MSHN with implementation of the remaining 2017/2018 Regional Strategic Plan objectives and assist with making proposed revisions for 2019-2020.
- Partner to address “298” pilot phase and related challenges
- Improve consistency, standardization and cost-efficiency in retained and delegated managed care activities
- Establish systems to improve performance in follow-up after hospitalization for mental illnesses between PIHPs and MHPs and within the MSHN region
- Home and Community Based Services Waiver Transition implementation
- 1115 Waiver implementation (if approved by CMS)
- Identify and implement improvements in region-wide approaches to inpatient care, from pre-admission screening systems to provider performance monitoring to contracting and all related systems.
- Address parity requirements by establishing effective regionally consistent utilization management systems, including regional eligibility, medical necessity, authorization, utilization review and related protocols and procedures to promote universal and equitable local access to care across the region
- Increase efficiency through collective provider network management functions
- Increase focus on meaningful metrics to measure performance and impacts
- Continue advocacy for systemic improvement in access to inpatient care and identify and develop sub-inpatient regional crisis response systems/options; Develop and implement (for possible Statewide use) systems for psychiatric inpatient care bed availability.

ANNUAL REPORT	
TEAM NAME:	Finance Council
TEAM LEADER:	Leslie Thomas, MSHN CFO
REPORT PERIOD COVERED: 10.1.16 - 9.30.17	

Purpose of the Finance Council

The Finance Council shall make recommendations to the Mid-State Health Network (MSHN) Chief Finance Officer (CFO), Chief Executive Officer (CEO) and the Operations Council (OC) to establish all funding formulas not otherwise determined by law, allocation methods, and the Entity's budgets. The Finance Council may advise and make recommendations on contracts for personnel, facility leases, audit services, retained functions, and software. The Finance Council may advise and make recommendations on policy, procedure, and provider network performance. The Council will also regularly study the practices of the Entity to determine economic efficiencies to be considered.

Responsibilities and Duties:

Areas of responsibility:
a. Budgeting – general accounting and financial reporting;
b. Revenue analyses;
c. Expense monitoring and management - service unit and recipient centered;
d. Cost analyses and rate-setting;
e. Risk analyses, risk modeling and underwriting;
f. Insurance, re-insurance and management of risk pools;
g. Supervision of audit and financial consulting relationships;
h. Claims adjudication and payment; and
i. Audits.

Monitoring and reporting of the following delegated financial management functions:
a. Tracking of Medicaid expenditures;
b. Data compilation and cost determination for rate setting;
c. FSR, Administrative Cost Report, MUNC and Sub-element preparation;
d. Verification of the delivery of Medicaid services; and
e. Billing of all third-party payers.

Monitoring and reporting of the following retained financial management functions:
a. PIHP capitated funds receipt, dissemination, and reserves;
b. Region wide cost information for weighted average rates;
c. MDHHS reporting; and
d. Risk management plan.

Defined Goals, Monitoring, Reporting and Accountability

Goals:

a.

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2016 and February 2017. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all CMHSP reports by April 2017. A favorable fiscal audits will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.
- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2016 Final Reports due to MDHHS February 28, 2017, are received from the CMHSPs to the PIHP. The goal for FY17 will be to spend at a level to maintain MSHN's anticipated combined reserves to 7.5% as identified by the board.
- Work toward a uniform costing methodology: Finance Council will continue working on uniform unit costing for services in FY 2017.
- Assure region wide rates are within acceptable deviations from state wide rates: The Medicaid Uniform Cost Report (MUNC) is due to MDHHS February 28, 2017. MDHHS will compile the PIHP reports and send an analysis to the PIHPs in June of 2017. Finance Council will follow our costing procedure and utilize this report to determine rates per service and costs per case for which we are not within one standard deviation of the PIHP averages within the state. Following the Finance Council procedure, an analysis will be performed of outliers and steps will be taken to adjust service provision or costing for service provision for all rates unless it is determined by the CEOs that our variances from the PIHP averages are acceptable.
- Completion of Finance Council Dashboard – MSHN staff and Finance Council members completed its work to populate the fiscal year 2015 Dashboard. The goal is to have the FY 2016 dashboard complete by April 2017.
- Uniform Administrative Costing – MSHN's CFO participates in the PIHP CFO council. A workgroup of this council developed definitions, grids, and guidelines for uniform administrative costing. Due to time constraints MSHN's Finance Council will develop a subset of guidelines for this reporting cycle.
- Monitor the impact on savings and reserves related to the change in Autism funding.
- Determine how New Managed Care Rules impact our Region and implement changes as necessary.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
- Monitor Medicaid expansion for any changes related to the Affordable Care Act and its impact on the region.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

Annual Evaluation Process

Past Year's Accomplishments

- FY 2016 fiscal audits were complete and submitted by the PIHP and 11 CMHSPs. The PIHP's and 10 of the CMHSP audits rendered an unqualified opinion. One CMHSP received a qualified opinion. CEI has not submitted its FY 2016 fiscal audit. Compliance Examinations were finalized for 11 CMHSPs. Each complied in all material aspects with attestation standards set forth by the American Institute of Certified Public Accountants. CEI's report is not yet complete and thus the PIHPs is not finalized.
- The FY 2016 Finance dashboard is complete. The committee members agreed to leave the same measures in place for FY 2017.
- The CMHSPs agreed in theory to implement the administrative guidelines from the PIHP CFO committee. These guidelines were further enhanced with MHSN clarification and acceptably measures. CMHSPs will demonstrate ongoing compliance through the Administrative Cost Report (ACR) narrative and also MSHN monitoring tools.
- As part of MSHN's FY 2017 Risk Management strategy, more than $9 million dollars was abated from the Internal Service Fund (ISF) to cover FY 2016 Autism expenses. MDHHS has increased Autism funding for FY 2018 and has also made the payment prospective. The payment change should mitigate cash flow concerns and may alleviate the need for future ISF abatement. The Finance Council developed an alternate disbursement strategy for FY 2018 revenue in order to have the funds align with the number of Autism consumers served.
- One significant impact of the new Managed Care Rules relates to calculation of the Medical Loss Ratio (MLR) for PIHPs. PIHP CFOs reviewed the rule and defined a consistent calculation methodology. This information has been shared with MDHHS, Operations Council, and Finance Council.
- New reports were developed to analyze the change in data submitted for interim, projection, and final Financial Status Reports (FSR). In addition, existing reports have enhanced frequency to identify potential fiscal risks sooner.

Upcoming Goals for Fiscal Year Ending September 30, 2018

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2017 and February 2018. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all CMHSP reports by April 2018. A favorable fiscal audits will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.
- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2017 Final Reports due to MDHHS February 28, 2018, are received from the CMHSPs to the PIHP. The goal for FY18 will be to spend at a level to maintain

MSHN's anticipated combined reserves to 7.5% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.

- Work toward a uniform costing methodology: MSHN has developed a Service Use Analysis suite of reports as a guideline for this process. The reports have been used to guide service activity collection information to identify significant variances related to service functions. The first phase of the process includes the review of five high volume codes.
- Assure region wide rates are within acceptable deviations from state wide rates: The Medicaid Uniform Cost Report (MUNC) is due to MDHHS February 28, 2018. MDHHS will compile the PIHP reports and send an analysis to the PIHPs in June of 2018. Finance Council will follow our costing procedure and utilize this report to determine rates per service and costs per case for which we are not within one standard deviation of the PIHP averages within the state. Following the Finance Council procedure, an analysis will be performed of outliers and steps will be taken to adjust service provision or costing for service provision for all rates unless it is determined by the CEOs that our variances from the PIHP averages are acceptable.
- Completion of Finance Council Dashboard – MSHN staff and Finance Council members completed its work to populate the fiscal year 2017 Dashboard. Uniform Administrative Costing – MSHN's CFO participates in the PIHP CFO council. A workgroup of this council developed definitions, grids, and guidelines for uniform administrative costing. Finance Council members agreed to follow the methodology guidance from MSHN. CMHSPs must show evidence of meeting MSHN's guidelines through its Administrative Cost Report (ACR) narrative.
- Monitor the impact on savings and reserves related to the change in Autism funding.
- Determine how New Managed Care Rules impact our Region and implement changes as necessary.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
- Monitor Medicaid expansion for any changes related to the Affordable Care Act and its impact on the region.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

ANNUAL REPORT

TEAM NAME: Information Technology Council

TEAM LEADER: Forest Goodrich, MSHN CIO

REPORT PERIOD COVERED: 10.1.16 – 9.30.17

Purpose of the Council or Committee: The MSHN IT Council (ITC) is established to advise the Operations Council (OC) and the Chief Executive Officer (CEO) and will be comprised of the Chief Information Officer (CIO) and the CMHSP Participants information technology staff appointed by the respective CMHSP CEO/Executive Director. The IT Council will be chaired by the MSHN CIO. All CMHSP Participants will be equally represented.

Responsibilities and Duties: The responsibilities and duties of the ITC include the following:

The IT Council will provide information technology leadership by collaborating for the purpose of better understanding MDHHS and other regulatory requirements, sharing knowledge and best practices, working together to resolve operational issues that affect both CMHSPs and MSHN, and achieve practical solutions. The IT Council will assist CMHSP IT staff in keeping up to date on current technology and with MDHHS and MSHN requirements by exchanging knowledge and ideas, and promoting standard technology practices and efficiency throughout the region. The IT Council will advise the MSHN CIO and assist with MSHN IT planning that benefits both MSHN and the individual CMHSP Participants.

Defined Goals, Monitoring, Reporting and Accountability:

The IT Council shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Representation from each CMHSP Participant at all meetings;
- Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness;
- Collaborate to develop systems or processes to meet MDHHS requirements (e.g., BH-TEDS reporting, SIS encounters, Rendering Provider NPI reporting);
- Accomplish annual goals established by the IT Council and/or OC; and
- Meet IT audit requirements (e.g., EQRO).

Annual Evaluation Process:

1. Past Year Accomplishments

   Representation from each CMHSP Participant at all meetings;
   - There was a 97% rate of attendance at FY17 ITC meetings. 100% attendance occurred in 11 meetings.

   Successfully submit MDHHS required data regarding quality, effectiveness and timeliness;
   - This process includes: encounters, BH-TEDS, QI, PI and CIR. Year-end statistics from MDHHS showed that we were 100% timely with encounter submissions.

- CMHSPs were successful with implementing the FY17 updated BH TEDS record changes and submitting all records. A summary report was submitted that identified areas that were difficult in capturing BH-TEDS information.

Facilitate health information exchange processes;

- Developed and implemented a successful method for tracking and reporting follow-up after hospitalization activities. Continued support for defining and developing outcome measures as needed by clinical leadership.
- Added a process for exchanging and aggregating LOCUS data to assist clinical leadership.
- Completed the process for receiving Medication Reconciliation information through MiHIN. Continuing the development of distribution and integration processes between MSHN and CMHSPs.
- Reached an agreement with Great Lakes Health Connect (HIE) and promoted the use of its VIPR tool within the region.

Goals established by Operations Council;

- Developed a training strategy for CMHSP use of care coordination licensing in the population health tool Integrated Care Delivery Platform (ICDP).
- Built balanced scorecard detail reports for IT council review and monitoring.
- Established a transition plan for BH-TEDS and encounter submissions through a new managed care information system.

Meet external quality review requirements;

- Health Services Advisory Group conducts the annual audit for MDHHS and it was successful. The materials that MSHN submitted were reviewed and approved without any findings. CMHSPs participated in the site review process and we continue to receive high marks for a highly functional delegated model and working well together.

2. Goals for fiscal year ending September 30, 2018
   - Active participation by all CMHSP representatives at each monthly meeting.
   - Meet current reporting requirements as defined by MDHHS for submitting information.
   - Continue to work on quality and outcome measures as needed for the MSHN region.
   - Improve balanced scorecard reporting processes to achieve or exceed target amounts.
   - Transition health information exchange (HIE) processes to managed care information system, when appropriate, to gain efficiencies in data transmissions.
   - Work toward achieving goals established by Operations Council.
   - Prepare for and pass audit requirements of the external quality review.

ANNUAL REPORT

TEAM NAME: Quality Improvement Council

TEAM LEADER: Kim Zimmerman, MSHN Director of Compliance, Customer Service and Quality

REPORT PERIOD COVERED: 10.1.16 – 9.30.17

Purpose of the Council or Committee: The Quality Improvement Council was established to advise the Operations Council and the Chief Executive Officer concerning quality improvement matters. The Quality Improvement Council is comprised of the Director of Customer Service, Compliance and Quality Improvement, the CMHSP Participants' Quality Improvement staff appointed by the respective CMHSP Participant Chief Executive Officer/Executive Director and a MSHN SUD staff representing Substance Use Disorder services. The Quality Improvement Council is chaired by the Director of Customer Service, Compliance and Quality Improvement. All Participants are equally represented on this council.

Responsibilities and Duties: The responsibilities and duties of the QIC include the following:

- Advising the MSHN Director of Customer Service, Compliance and Quality Improvement and assisting with the development, implementation, operation, and distribution of the Compliance Plan, Quality Assessment and Performance Improvement Plan (QAPIP) and supporting MSHN policies and procedures.
- Reviewing and recommending changes/revisions to the Compliance Plan and QAPIP, related policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the Compliance Plan and QAPIP.
- Determining the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focus.
- Recommending and monitoring the development of internal systems and controls to carry out the Compliance Plan and supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.

Defined Goals, Monitoring, Reporting and Accountability:

The QIC established metrics and monitoring criteria to evaluate progress on the following primary goals:

- Implementation of the Quality Assessment and Performance Improvement Plan (QAPIP),
- Implementation of the Compliance Plan;
- Implementation of the action plans related to the Application for Participation (AFP);
- Performance Measures related to QI
- Compliance and oversight of the above identified areas.

Additionally, the QIC seeks to assess and achieve the following secondary goals:

- Retained function contracts achieved defined results;
- Collaborative relationships are retained;
- Reporting progress through Operations Council;
- Regional collaboration regarding expectations and outcomes;
- Efficiencies are realized through standardization and performance improvement; and

- Benefits are realized through our collective strength

Annual Evaluation Process:

a. Past Year's Accomplishments: The QIC had eleven (11) meetings during the reporting period and in that time completed the following tasks:
    - Reviewed and revised the MSHN Corporate Compliance Plan
    - Annually reviewed and revised (as needed) current regional policies and procedures in areas of Quality Improvement and Compliance
    - Developed new Consent to Release Information policy to meet contract compliance
    - Implementation, data collection, summary report and quarterly review of MHSIP and YSS satisfaction surveys
    - Data collection, summary report and quarterly review of Behavior Treatment Data
    - Data collection, summary report and quarterly review of Performance Indicators (MMBPIS) (including revisions to annual report template and reporting instructions for consistency of data)
    - Data collection, summary report and quarterly review of Critical Incidents
    -
    - Feedback and participation in the External Quality Reviews (Performance Improvement Project and Performance Monitoring Validation)
    - Revised, implemented and providing ongoing monitored for two (2) regional Performance Improvement Projects (PIP) (HEDIS Measure and the RSA/RAS)
    - Reviewed and provided feedback on the FY17 MSHN Compliance Summary report
    - Reviewed Medicaid Event Verification process and approved of revisions to the site review process
    - Continued coordination of efforts with the MSHN Utilization Management Committee specific to monitoring outcome measures
    - Provided coordination and monitoring for the MDHHS site review and the required plans of correction
    - Revised quarterly reporting formats for performance measures to focus more on trend analysis, identification of outliers and development of region wide quality improvements
    - Reviewed and revised the MSHN FY16-17 QAPIP
    - Completed the FY16-17 annual QAPIP effectiveness review
    - Reviewed the FY16 and FY17 SUD Satisfaction Survey Summary report
    - Reviewed and approved of revisions to the Annual Delegated Managed Care site review process
    - Developed QIC balanced scorecard performance report and reviewed quarterly
    - Developed project study for Follow Up after Hospitalization contract requirement (inclusive of data analysis, protocols, performance standards, plans of correction and quarterly review)
    - Completed annual review and update of QIC charter
    - Developed project study for review of performance measure "Diabetes Monitoring for Schizophrenia Diagnosis" (inclusive data analysis, protocols, performance standards, plans of correction and quarterly review)

b. Upcoming Goals for Fiscal Year Ending, September 30, 2018 (need to establish goals for FY18)
    - Report and complete an assessment of the annual effectiveness of the QAPIP

- Conduct ongoing annual review of required policies
- Continue implementation, monitoring and reporting of progress on the two (2) regional Performance Improvement Projects
- Continue monitoring of quality and performance improvement related the QAPIP
    - Behavior Treatment Review
    - Critical Incidents
    - Performance Improvement (MMBPIS)
    - Consumer Satisfaction
- Complete annual review and revisions of Corporate Compliance Plan
- Provide Feedback on annual Compliance Summary Report
- Review available healthcare data for identification of trends and quality improvement opportunities
- Review Clinical Outcomes Data (Autism, CAFAS, SIS, LOCUS, etc) in coordination with other MSHN committees for effectiveness, comparison and opportunities for quality improvement
- Explore BH-TEDS data as related to QI efforts

II. Advisory Council FY17 Accomplishments & FY18 Goals

ANNUAL REPORT

TEAM NAME: Regional Consumer Advisory Council

TEAM LEADER: Heather Nichols, Chair Person

REPORT PERIOD COVERED: 10.1.16 – 9.30.17

Purpose of the Consumer Advisory Council: The Consumer Advisory Council will be the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports and coordinating agency requirements in the region. The Consumer Advisory Council includes representatives from all twelve (12) CMHSP Participants of the region.

Responsibilities and Duties: Other responsibilities and duties of the CAC shall include the following:

- Provide representation to the MSHN CAC on behalf of the local consumer councils;
- Assist with effective communication between MSHN and the local consumer advisory mechanisms;
- Advise the MSHN Board of Directors relative to strategic planning and system advocacy efforts for public mental health;
- Advise MSHN Board of Directors related to regional initiatives for person-centered planning, self-determination, health care integration, independent facilitation, recovery, eligibility management, network configuration, and other consumer-directed options;
- Provide recommendations related to survey processes, customer satisfaction, consumer involvement opportunities, consumer education opportunities, quality and performance improvement projects and other outcome management activities;
- Focus on region-wide opportunities for stigma reduction related to mental health and substance use disorder issues.

Defined Goals, Monitoring, Reporting and Accountability

The CAC shall review aggregate reports received from the Quality Assessment and Performance Improvement Program (QAPIP), provide recommendations, and give guidance and suggestions regarding consumer-related managed care processes.

Provide feedback for regional initiatives designed to encourage person-centered planning, self-determination, independent facilitation, anti-stigma initiatives, community integration, recovery and other consumer-directed goals.

Share ideas and activities that occur at the local CMHSP level and create an environment that fosters networking, idea sharing, peer support, best practices, and resource sharing.

Annual Evaluation Process:

- Past Year's Accomplishments: The RCAC had 6 meetings during the reporting period in that time they completed the following tasks:
    - Reviewed the FY16 Annual Compliance Report
    - Reviewed and provided feedback on the Annual FY16 -17 Compliance Plan
    - Reviewed changes to the Consumer Handbook
    - Reviewed Quality Improvement Performance Measure Reports that included Performance Indicators, Behavior Treatment Review and Oversight, Critical Incidents, Grievance and Appeals, and Medicaid Fair Hearings
    - Reviewed and provided input on the MHSIP and YSS satisfaction survey results
    - Reviewed and provided feedback on the SUD satisfaction survey results
    - Discussed internal delegated managed care site reviews and outcomes
    - Reviewed the MDHHS National Core Indicator (NCI) reports (A Guide to PCP and The Importance of Relationships) and provided feedback on identified barriers
    - Reviewed and approved RCAC annual effectiveness report
    - Reviewed and provided feedback on the Quality Assessment and Performance Improvement
    - Program (QAPIP) Annual Effectiveness Report (Fy16)
    - Annual review of MSHN customer service policies and procedures for feedback
    - Education on Utilization Management, Autism and HAB Support Waiver from MSHN staff
    - Reviewed and provided feedback on the RAS and RSA satisfaction survey summary reports
    - Reviewed outcomes from Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and Performance Improvement Project (PIP) annual reviews
    - Reviewed and provided feedback on the MDHHS HSW and SUD site review results
    - Education on 298 legislation
    - Reviewed and revised committee charter
    - Reviewed and provided feedback regarding MSHN's Strategic Plan
    - Developed practice for ongoing communication between MSHN and local councils
    - Provided input on MSHN's Balanced Scorecard
    - Improved group dynamic and cohesiveness

- Upcoming Goals for Fiscal Year Ending, September 30, 2017:
    - Provide input on regional educational opportunities for stakeholders
    - Provide input for ongoing strategies for the assessment of primary/secondary consumer satisfaction
    - Review regional survey results including MHSIP, YSS, and external quality reviews
    - Review annual compliance report
    - Annual review and feedback on QAPIP
    - Annual Review and Feedback on Compliance Plan
    - Annual review of policies and procedures related to Customer Service
    - Annual review of MSHN Consumer Handbook
    - Review and advise MSHN Board relative to strategic planning and advocacy efforts
    - Provide group advocacy within the region for consumer related issues
    - Convene special work sessions to develop letters of support/advocacy on regional issues to address time sensitive legislation as a group

III. Oversight Board FY17 Accomplishments & FY18 Goals

ANNUAL REPORT

TEAM NAME: SUD Oversight Policy Board

TEAM LEADER: Chairman John Hunter, SUD Board Member

REPORT PERIOD COVERED: 10.1.16 – 9.30.17

Purpose of the Board: The Mid-State Health Network (MSHN) Substance Use Disorder (SUD) Oversight Policy Board (OPB) was developed in accordance with Public Act 500 of 2012, Section 287 (5). This law obliged MSHN to "establish a substance use disorder oversight policy board through a contractual agreement between [MSHN] and each of the counties served by the community mental health services program." MSHN/s twenty-one (21) counties each have representation on the OPB, with a designee chosen from that county. The primary decision-making role for the OPB is as follows:

- Approval of any portion of MSHN's budget containing local funding for SUD treatment or prevention, i.e. PA2 funds
- Has an advisory role in making recommendations regarding SUD treatment and prevention in their respective counties when funded with non-PA2 dollars.

Annual Evaluation Process:

a. Past Year's Accomplishments:
    - Received updates on the following:
        - MSHN Strategic Plan
        - SUD three-year Strategic Plan
        - MSHN SUD Prevention Services
    - Election of OPB Board Officers
    - Approval of Public Act 2 Funding for FY17
    - Received PA2 Funding reports – receipts & expenditures by County
    - Received Quarterly Reports on Prevention and Treatment Goals and Progress
    - Received reports on SUD regional site review status
    - Received Opioid regional response
    - Received information on MDHHS State Targeted Response Grants
    - Received overdose death reports
    - Received education on Prevention Activities in the region
    - Offered insight on SUD programming, funding and functions
    - Offered recommendations and insight regarding effective use of collaborative and community efforts
    - Received updates on legislative activities related to SUD funding and 298 boilerplate language

b. Upcoming Goals for FY18 ending, September 30, 2018:

- Approve use of PA2 funds for prevention and treatment services in each county;
- Define role of SUD OPB related to monitoring, advisement and use of all non-local funding
- Improve communications with MSHN Leadership, Board Members and local coalitions
- Share prevention and treatment strategies within region
- Provide advisory input to the MSHN Board of Directors regarding the overall agency strategic plan and SUD budget; and
- Monitor SUD spending to assure it occurs consistent with PA 500.

IV. Committee & Workgroup FY17 Accomplishments & FY18 Goals

ANNUAL REPORT

TEAM NAME: Autism Benefit Workgroup

TEAM LEADER: Barb Groom, MSHN Waiver Coordinator

Katy Hammack, MSHN Waiver Coordinator

REPORT PERIOD COVERED: 10.1.16 – 9.30.17

Purpose of the Council or Committee:
The Autism Benefit Workgroup was established to initiate and oversee coordination of the autism benefit for the region. The Autism Benefit Workgroup is comprised of Mid-State Health Network's (MSHN) Waiver Coordinator and the Community Mental Health Service Prover (CMHSP) autism benefit staff who are appointed by their respective CMHSP Chief Executive Officer/Executive Director. The Autism Benefit Workgroup is chaired by the Waiver Coordinator. All CMHSPs are equally represented on this council.

Responsibilities and Duties: The responsibilities and duties of the Autism Benefit Workgroup include the following:

- Advising the MSHN Waiver Coordinator(s).
- Assist with the development, implementation, and operation of the autism benefit within the region, and supporting MSHN policies and procedures.
- Reviewing and recommending changes and/or revisions to policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the autism benefit program.
- Determining the appropriate strategy or approach to promote compliance and detect potential violations and areas of risk as well as areas of focus, consistent with sound clinical documentation and service billing practices.
- Recommending and monitoring the development of internal systems and controls to carry out the supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing processes that incorporate best practices and encourage continuous quality improvement for autism program operations and service-related outcomes.

Defined Goals, Monitoring, Reporting and Accountability:
The autism benefit workgroup via the established metrics and monitoring criteria identified in the MSA 15-59 Bulletin to evaluate progress on the following primary goals:

- Reduction and elimination of overdue re-evaluations;
- Reduction and elimination of overdue Individual plan of service (IPOS);
- Hours of Applied Behavior Analysis (ABA) within a quarter must be within the IPOS suggested range for the intensity of service plus or minus a variance of 25%.

- Number of hours of ABA observation during a quarter are equal to or greater than 10% of the total direct ABA service provided.
- Tracking of pending cases (only referred and awaiting an evaluation);
- Implementation of the agreed upon correction actions related to the 2017 Michigan Department of Health and Human Services (MDHHS) Autism Benefit site review findings;
- Compliance and oversight of the above identified areas.

Additionally, the autism benefit workgroup seeks to assess and achieve the following secondary goals:

- Collaborative relationships are retained;
- Continue to increase provider capacity
- Reporting progress through the MSHN Clinical Leadership Council or MSHN Quality Improvement Council, as identified;
- Regional collaboration regarding expectations and outcomes;
- Efficiencies are realized through standardization and performance improvement; and
- Benefits are realized through our collective strength (knowledge, experience, abilities, and resources).

<u>Annual Evaluation Process:</u>

b. Past Year's Accomplishments
   - The Autism Benefit Workgroup met quarterly and as needed
   - The Autism Benefit Workgroup prepared for and participated in the MDHHS site review of the CMHSP autism programs and continued to work on related products.
   - Updated autism policy to reflect the new MSA-1559 policy due to expansion.
   - Continued to provide several training opportunities aimed at increasing capacity and implementation of ABA treatment services.
   - Provided guidance on the use of the new ABA CPT Codes.
   - Update forms for Autism Benefit (Referral, Enrollment, Re-evaluation and Disenrollment).
   - Focused on performance data reports on the 3 elements (overdue reevaluations, overdue IPOS, service outside the plus/minus 25% identified in the IPOS).
   - Created and maintained a monthly report on the status of the autism benefit.
   - Created guide for tracking conditions needed for autism payment.
   - Provided guidance and assistance on expected credentialing practices and oversight.
   - Worked on plan for behavior health technician retention.
   - Clarified expectations regarding school hours and ABA treatment expectations.

c. Upcoming Goals for Fiscal Year Ending, September 30, 2017
   - Continued improvement in autism performance indicators, with application of corrective actions.
   - Continue to address university partnerships, and contractual opportunities with the goal of increasing capacity.
   - Increase opportunities to expand provider system in the region.
   - Develop standardized ABA contractual language within our region.
   - Develop a procedure related to ABA during typical school hours.
   - Increase understanding and provide guidance on cases that have both Medicaid and private insurance.
   - Establish new process for ABA related trainings due to updated funding mechanism.

ANNUAL REPORT

TEAM NAME: Clinical Leadership Committee

TEAM LEADER: Linda Schneider, CLC Chair & Dani Meier, MSHN CCO

REPORT PERIOD COVERED: 10/1/16 – 9/30/17

Purpose of the Council or Committee:

The MSHN Operations Council (OC) has created a CLC to advise the Pre-Paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of the Entity and the region. Respecting that the needs of individuals served and communities vary across the region, it will inform, advise, and work with the CEO and OC to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Responsibilities and Duties:

The responsibilities and duties of the CLC include the following:

- Advise the CEO and OC in the development of clinical best practice plans for MSHN (including implementation and evaluation);
- Advise the CEO and OC in areas of public policy priority including high risk, high cost, restrictive interventions, or that are problem prone;
- Provide a system of leadership support, collaborative problem solving and resource sharing for difficult case discussion ("grand rounds");
- Support system-wide sharing though communication and sharing of major initiative (regional and statewide);
- Assure clinical policies and practices are operational, effective, efficient and in compliance with applicable contracting and regulatory bodies; and
- Undertake such other duties as may be delegated by the CEO or OC.

Defined Goals, Monitoring, Reporting and Accountability:

The CLC shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Improved health outcomes;
- Increased use of evidenced based practices;
- Improved collaboration of the region's clinical leadership including member satisfaction with the committee process and outcomes;
- Increased use of shared resources and problem solving for difficult cases.

Additionally, the CLC seeks to assess and achieve the following secondary goals:

- CEO and OC satisfaction with CLC advisory role;
- Staff perception and sense of knowing what is going on; and
- Efficiencies are realized through standardization, performance improvement and shared resources.

Annual Evaluation Process:

Past Year's Accomplishments:

- Identified CLC "leads" to champion areas of shared strategic purpose between CLC's charter and MSHN strategic goals and created CLC workgroups to address those shared activity areas;
- Shared CLC-MSHN focus areas included: improved population health, work with MHPs on ED use reduction, primary care coordination with use of data (e.g. CC360, ADT feeds, Zenith training for CMHs, etc.), integration of SUD into care coordination activities, impacting opioid prescribing practices, implementation of standardized assessment tools, and improved standardization of clinical practices;
- Progress with CLC Workgroup focused on standardization of LOCUS to determine levels of care with regional consistency;
- Ongoing discussion of regional applications of current assessment tools, CAFAS, SIS, and discussion of MDHHS notification that the GAIN (Global Assessment of Individual Needs) will be the MDHHS-required SUD assessment tool expected starting in FY19;
- Continuous improvement on practices for coordination of care with primary care;
- Deepening engagement with Knowledge Services Project through identification of key data elements that can be mined, analyzed and used to inform development of clinical practice, procedure and policies;
- Development of protocols to inform CLC approach to performance measures where individual CMHs are not meeting target goals;
- Ongoing review of MSHN Balanced Score Card with focus on veterans, ADHD follow up, collaboration with MDOC, trauma-informed care, and continuity of care;
- Collaboration with MSHN's new Veteran Navigator to collaborate and improve access and services for Veterans across CMHs;
- Ongoing discussion of fidelity issues around Evidence Based Practices, e.g. ACT and LOCUS;
- Ongoing CLC review and discussion of MSHN and MDHHS notices, policies and procedures (e.g. Service Philosophy and Treatment Philosophy, expectation for mobile child crisis services, etc.
- Discussion of Healthy Michigan overspending and cost containment efforts with attention to impact on services;
- Continuing regional utilization of CMHSP hubs for distribution of Narcan overdose reversal medication kits and provision of training for use of overdose reversal kits;
- Discussion of expectation of intensive crisis stabilization for youth statewide and process for implementation;
- Improved process for audits of CMH client charts (e.g. pre-audit electronic access to charts and discussion of items in DMC chart tool);
- Discussion of NCQA expectations and impacts on CMHSPs;

- Continuous oversight and improvement of regional 24/7/365 access protocol for SUD consumers and discussion of access to psychiatric services for SUD clients;
- Discussion/sharing of prevention activities that are occurring at the CMHSP level and ideas for increased collaboration with community partners;
- Continuous review of Training on Medication-Assisted Treatment (MAT) for CMHSP clinical staff by MSHN's SUD Medical Director, Dr. Bruce Springer;
- Continuous review and input re: Network Adequacy Assessment;
- Reviewed and provided input on Care Coordination training (use of Zenith and ICDP) for CMHSP's in the region;
- Engaged new MSHN Medical Director, Dr. Zakia Alavi, in review of CMHSP protocols, processes, and policies.

Goals for Fiscal Year 2018; Ending September 30, 2018

The CLC will be involved in monitoring, developing and recommending improvements to:

- Medical Population health outcomes in collaboration with MSHN's ongoing work with the region's Medicaid Health Plans;
- Implementation of regional consistency in use of LOCUS and training (by MDHHS) in the GAIN;
- Ongoing efforts to strengthen coordination of care between primary and behavioral health care services and seek to expand best practices;
- HCBS implementation;
- Continued implementation of competencies in diagnosis and treatment of co-occurring conditions, trauma, gender competence and cultural competence (including military competency training);
- Continuing process improvement service coordination between providers, different levels of care, etc.;
- Expansion of integrated prevention services;
- Building capacity in psychiatric services, for children and adolescents in particular;
- Support expansion of MAT services and distribution of Naloxone;
- Regional consistency in access standards and delivery of services.

Role and Perspectives of Medical Directors:

- MSHN Medical Director, Dr. Zakia Alavi, will host a meeting of CMH medical directors in early 2018 to discuss regional and local concerns from the medical directors' perspectives

ANNUAL REPORT

TEAM NAME: Customer Service Committee

TEAM LEADER: Dan Dedloff, MSHN Customer Service & Rights Specialist

REPORT PERIOD COVERED: 10.1.16 – 09.30.17

Purpose of the Customer Service Committee: This body was formed to draft the Consumer Handbook and to develop policies related to the handbook, the Regional Consumer Advisory Council (RCAC), and Customer Services. The Customer Services Committee (CSC) will continue as a standing committee to assure the handbook is maintained in a compliant format, and to support development and implementation of monitoring strategies to assure regional compliance with CS standards. This committee will be supported by the MSHN Compliance Officer (CO) and will report through the Quality Improvement Council (QIC).

Responsibilities and Duties: The responsibilities and duties of the CSC will include:

1. Advising the MSHN CO and assisting with the development, implementation and compliance of the Customer Services standards as defined in the Michigan Department of Health and Human Services (MDHHS) contract and 42 CFR including the Balanced B udget Act Requirements;
2. Reviewing and providing input regarding MSHN Customer Services policies and procedures;
3. Reviewing, facilitating revisions, publication, and distribution of the Consumer Handbook;
4. Facilitating the development and distribution of regional Customer Services information materials;
5. Ensuring local-level adherence with MSHN regional Customer Services policies through i mplementation of monitoring strategies;
6. Reviewing semi-annual aggregate grievances, appeals, second opinions, recipient rights and Medicaid Fair Hearings reports;
7. Reviewing audit results from EQR and MDHHS site reviews and assisting in the development and oversight of corrective action plans regarding Customer Services;
8. Participating in MSHN's Delegated Managed Care Review process;
9. Assisting in the formation and support of the RCAC, as needed; and
10. Individual members serving as ex-officio member to the RCAC.

Defined Goals, Monitoring, Reporting and Accountability

The CSC shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Customer Service Handbook completion, updates and SUD incorporation;
- Regional Customer Service policy development;
- Tracking and reporting Customer Service information; and
- Compliance with Customer Service Standards and the Grievance and Appeal Technical Requirement, PIHP Grievance System for Medicaid Beneficiaries.

Additionally, the CSC seeks to assess and achieve the following secondary goals:

- Retained function contracts achieved the defined results;
- Collaborative relationships are retained;
- Reporting progress through Quality Improvement Council;
- Regional collaboration regarding customer service expectations and outcomes;
- Efficiencies are realized through standardization and performance improvement; and
- Benefits are realized through our collective strength.

Annual Evaluation Process:

a. Past Year's Accomplishments: The CSC had Nine (9) meetings during the reporting period in which they completed the following tasks:
   - Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN Consumer Handbook
   - Facilitated publication and electronic regional distribution of the MSHN Consumer Handbook: Spanish language version
   - Reviewed and revised regional policies and procedures in areas of Customer Service/Customer Handbook, Customer/Consumer Service Policy, Regional Consumer Advisory Council, Information Accessibility/Limited English Proficiency (LEP), Medicaid Beneficiary Appeals/Grievances, Advance Directives, Customer Service/Confidentiality & Privacy, and Reporting Medicaid Beneficiary Appeals, Grievances, Recipient Rights and Administrative Hearings.
   - Review, analyze and report regional customer service information including:
     - Grievances
     - Appeals
     - Second Opinions
     - Medicaid Fair Hearings
     - Recipient Rights
     - Quarterly Performance Indicators (review only)
   - Provided review and feedback related to Consumer Satisfaction Surveys (MHSIP, YSS, and FY2017 Substance Use Disorder Consumer Satisfaction)
   - Initiated development of regional standardization of the Adverse Benefit Determination (formerly Action Notice).

b. Upcoming Goals for Fiscal Year Ending, September 30, 2018
   - Conduct ongoing annual review of required policies and procedures
   - Conduct annual review and revisions to MSHN Consumer Handbook to reflect contract updates and regional changes
   - Continue to develop, where applicable, standardized elements required of regional forms
   - Continue reporting and monitoring customer service information
   - Evaluate, oversight & monitor of regional grievances & appeals, in accordance with CS standards
   - Review consumer satisfaction surveys, develop and implement action plans as required per the customer service elements
   - Monitor and improve as needed, the compliance with timeliness indicators for the MSHN Appeals, Grievances, and Second Opinion requirements
   - Continue to identify Educational Material/Brochures/Forms for standardization across the region

- Increase coordination and communication with the Regional Consumer Advisory Council

ANNUAL REPORT

TEAM NAME: HSW Workgroup

TEAM LEADER: Katy Hammack, MSHN Waiver Coordinator

REPORT PERIOD COVERED: 10.01.16 – 9.30.17

Purpose of the Council or Committee:

The Habilitation Supports Waiver (HSW) Workgroup was established to initiate and oversee coordination of the HSW benefit for the region. The HSW Workgroup is comprised of the MSHN Waiver Coordinator and the CMHSP HSW Coordinator staff appointed by the respective CMHSP Chief Executive Officer/Executive Director. The HSW Workgroup is chaired by the Waiver Coordinator.

Annual Evaluation Process:

a. Past Year's Accomplishments
   - The HSW Workgroup met quarterly during FY 17.
   - The HSW Workgroup incorporated changes to MDHHS forms used for HSW eligibility.
   - The HSW Workgroup ensured priority management of cases through ranking of Supports Intensity Scale (SIS) ranked standard scores.
   - Reviewed and discussed upcoming Home and Community Based Services (HCBS) rule changes as they relate to the HSW.
   - Prepared survey process for those selected in the sample phase of the HCBS changes.
   -
   - Reviewed HSW dashboard data and formulate plan for correction-open slots, recoupments, recertification data, overdue IPOS, overdue consents.
   - Followed up on the 2016 MDHHS site review results.
   - Coordinated and reviewed HSW Corrective Action Plan (CAP).
   - Developed action plan and follow through on HSW CAP.
   - Reviewed and provided input into the HCBS survey process for C-Waiver and B3 Waiver.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2017
   - Continue to use and institute corrective process for report set for overseeing HSW performance within the region.
   - Continue focus on filling number of slots available for consumers within the region.
   - Oversee the HCBS rule change as set forth by MDHHS including but not limited to:
     a. Ensure beneficiaries and providers complete HCBS survey. Engage in process to follow up with non-compliant providers who have not completed a survey.
     b. Assist providers in coming into compliance with the HCBS rule.

c. Create process for random selection of providers for onsite review of corrective action plan review.
d. Assist in the transition process for beneficiaries residing in settings that cannot come into compliance.
e. Continue the ongoing monitoring of providers and CMHSP collaboration with regards to the HCBS rule.

- Ensure proper implementation of new 1115 waiver once approved by the Centers for Medicare and Medicaid (CMS).
- Meet quarterly to address regional needs.

ANNUAL REPORT

TEAM NAME: Provider Network Management Committee

TEAM LEADER: S. Vandermay CMHSP Participant

REPORT PERIOD COVERED: 10.1.16 – 9.30.17

Purpose of the Council or Committee: The Provider Network Management Committee (PNMC) is established to provide counsel and input to Mid-State Health Network (MSHN) staff and the Operations Council (OC) with respect to regional policy development and strategic direction. Counsel and input will typically include: 1) network development and procurement, 2) provider contract management (including oversight), 3) credentialing, privileging and primary source verification of professional staff, and 4) periodic assessment of network capacity. In fulfilling its charge, the PNMC understands that provider network management is a Prepaid Inpatient Health Plan function delegated to Community Mental Health Service Programs (CMHSP) Participants. Provider network management activities pertain to the CMHSP direct operated and contract functions.

Responsibilities and Duties: The responsibilities and duties of the PNMC include the following:

- Advise MSHN staff in the development of regional policies for Provider Network Management;
- Establish regional priorities for training and establish training reciprocity agreements for (CMHSP) Sub-Contractors;
- Support development of regional PNM monitoring tools to support compliance with rules, laws, and the PIHPs Medicaid contract with MDCH.
- Provide requested information and support development of periodic Network Capacity Assessment;
- Monitor results of retained functions contract for Network Capacity Assessment;
- Support development and implementation of a Regional Strategic Plan;
- Look for opportunities and recommend strategies to establish uniformity in contract language and rates, to achieve best value;
- Continue to develop intra-regional reciprocity systems to increase efficiencies;
- Recommend and deploy strategies for sub-contractor credentialing reciprocity agreements.

Defined Goals, Monitoring, Reporting, and Accountability: The PNMC shall establish goals consistent with the MSHN Strategic Plan and to support compliance with the MDCH – PIHP contract including:

1. Completion of a Regional Network Capacity Assessment; establish and execute plans to address service gaps;
2. Recommend policy and practices for improved network management compliance and efficiency;
3. Establish performance improvement priorities identified from monitoring of delegated provider network management functions;
4. Increased efficiency through regional contracting when providers are shared;
5. Development of reciprocity agreements for sub-contract credentialing/re-credentialing,

training, performance monitoring, and standardized contract language;
6. Implement strategies to establish regional inpatient rate negotiations for best value; and
7. Fully execute regional agreements with Medicaid Health Plans due to rebidding of health plans; strategic relationship to align with additional health plan and PIHP contract requirements.

Annual Evaluation Process:

- Past Year's Accomplishments: The PNMC had ten meetings during the reporting period in that time they completed the following tasks:
  - Address recommendations from the 2016 assessment of Network Adequacy as it relates to provider network functions;
  - Recommended policy and practices for improved network management compliance and efficiency;
  - Supported FI workgroup toward the development of a standardized Fiscal Intermediary contract and monitoring protocol;
  - Informed Regional Inpatient Operations Workgroup relative to contract language;
  - Developed a plan to implement new managed care rules related to provider network functions;
  - Developed PNMC scorecard.

- Upcoming Goals for Fiscal Year Ending, September 30, 2018
  - Address recommendations from the 2017 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs;
  - All CMHSPs are utilizing the regional psychiatric inpatient contract for new or renewal contracts executed on or after April 1, 2018;
  - Support the statewide and intra-regional inpatient provider performance monitoring protocol resulting in improved provider performance and administrative efficiencies;
  - In concert with MSHN, successfully negotiate regional inpatient contracts resulting in improved rates and performance results;
  - Support the intra-regional Fiscal Intermediary provider performance monitoring protocol resulting in improved provider performance and administrative efficiencies;
  - Implement new managed care rules related to provider network functions effective during FY18;
  - Update PNMC scorecard;
  - To the extent deemed appropriate, address NCQA accreditation requirements as it relates to delegated credentialing;
  - In concert with MSHN Waiver Director, develop and implement practice strategies for the provider network to comply with the new HCBS standards, including those related to onboarding new providers.

ANNUAL REPORT

TEAM NAME: Regional Inpatient Operations Workgroup

TEAM LEADER: J. Sedlock (MSHN), S. Lindsey (Saginaw CMHSP)

REPORT PERIOD COVERED: 2.15.17 – 9.30.17

Purpose of the Regional Psychiatric Inpatient Operations Workgroup:

The MSHN Operations Council created this ad hoc, temporary, Regional Psychiatric Inpatient Operations Workgroup to make recommendations to MSHN and participating CMHSPs with regard to standardizing, across the MSHN region, clinical procedures, forms, tools and systems as well as administrative procedures, forms, tools and systems that are associated with psychiatric inpatient care, provider network procurement (including contracting), provider network management (including provider performance monitoring and performance improvement), credentialing and privileging, and any other related systems.

Responsibilities and Duties:

The responsibilities and duties of the Regional Psychiatric Inpatient Operations Workgroup included the following:

- Develop and submit to the Operations Council a detailed work plan;
- Develop a single set of psychiatric inpatient provider performance standards, including pre-admission, admission, continuing care, discharge, and aftercare as well as contract compliance, performance improvement and any related/applicable administrative standards;
- Develop a single, regional psychiatric inpatient provider performance monitoring (site review) template (inclusive of recipient rights review standards/criteria);
- Develop standardized tools for routine operations in the areas of initial authorizations, continuing stay reviews, discharge plans, and related clinical processes, procedures and forms;
- Develop a single psychiatric inpatient provider contract template;
- Develop any necessary recommended policies, procedures, forms, templates or other tools necessary to achieve regional consistency and standardization of operations;
- Consult with MSHN/CMHSP colleagues of different subject matter expertise to ensure work products are endorsed by other MSHN Councils and/or Committees;
- Provide minutes/notes of its meetings to the (CLC or PNMC)
- Undertake such other responsibilities as may be necessary to achieve the desired outcomes and deliverables detailed in this Workgroup Charter.

Annual Evaluation Process:

a . Accomplishments:

- Developed a single set of psychiatric inpatient provider performance standards, including pre-admission, admission, continuing care, discharge, and aftercare as well as contract compliance, performance improvement and any related/applicable administrative standards;

- Adopted the state-wide inpatient monitoring protocol and site review template (inclusive of recipient rights review standards/criteria);
- Developed a single psychiatric inpatient provider contract template;
- Developed policies, procedures, forms, templates or other tools necessary to achieve regional consistency and standardization of operations;
- Consulted with MSHN/CMHSP colleagues of different subject matter expertise to ensure work products are endorsed by other MSHN Councils and/or Committees;
- Provided minutes/notes of its meetings to the (CLC or PNMC);
- Identified and referred to other MSHN Councils and/or Committees responsibilities necessary to achieve the desired outcomes and deliverables detailed in this Workgroup Charter.

<u>Recommendations/Action for Operations Council:</u>

- Approve the regional inpatient contract;
- Adopt the statewide inpatient monitoring protocol;
- Maintain an ad-hoc workgroup to address regional inpatient operations contract matters;
- Develop a process for contract language change management. The workgroup recommends the following: address regional inpatient workgroup approved changes as an amendment, tracked and prepared by MSHN and distributed to CMHSP's;
- Establish a contract renewal schedule and ensure proposed edits are addressed by July 31st per contract language;
- Develop a strategy to negotiate/achieve lowest rate *per hospital*. Workgroup recommends taking a collaborative approach, coordinated by MSHN and led by the home CMHSP based on geographic location of the hospital and transitioning to a MSHN led process as relationships are established. Membership to include a MSHN representative, home CMSHP representative, and one additional CMHSP representative. (Southwest Michigan Behavioral Health has successfully achieved standard regional rates per hospital using this approach)
    - Identify representatives from each CMHSP; MSHN to host a meeting with representatives to discuss negotiation strategy/considerations;
- Upon approval from Operations Council, execute the regional inpatient contract for any new contract, extension, or renewal occurring on or after 4.1.18, with all CMHSPs utilizing the contract by 10.1.18;
- Refer the following topics to other MSHN Councils and/or Committees:
    - Review of regional transportation costs associated with inpatient stays – Finance Council
    - Out-of-State placement coding – Finance Council
    - Development of regional aftercare standards (effective care transitions, warm handoff, avoid readmissions) – Clinical Leadership Committee
    - System for providing feedback to hospitals – Shifted to Statewide Inpatient Steering Committee/Workgroups

ANNUAL REPORT

TEAM NAME: SIS Workgroup

TEAM LEADER: Todd Lewicki, MSHN UM and Waiver Director

REPORT PERIOD COVERED: 10.01.16 – 9.30.17

Purpose of the Council or Committee:

The Supports Intensity Scale (SIS) Implementation Workgroup was established to initiate and oversee coordination and implementation of the Supports Intensity Scale assessments for the region. The SIS Implementation Workgroup is comprised of the Waiver Director and the CMHSP SIS assessor staff appointed by the respective CMHSP Chief Executive Officer/Executive Director. The SIS Implementation Workgroup is chaired by the Waiver Director.

Annual Evaluation Process:

a. Past Year's Accomplishments
   - The SIS Workgroup met quarterly during FY17.
   - Creation of SIS Assessment database that included aggregate completion data as well as ranking of standard scores for potential HSW consumer review.
   - Assessment completion tracking was a major focus, including discussion around assessor expansion and planning.
   - Fully utilized SIS Quality Lead function.
   - Discussion of support types in SIS assessment.
   - Tracking of SIS completions and reasons.
   - Reinforced use in planning for support of person centered planning processes relative to all other clinical information.
   - Established contract with MORC to assist in SIS assessment completion.
   - Ongoing data reviews, including completions, domain data, planning related to connection to person centered planning.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2018
   - Utilize appropriate resources to increase SIS assessment completion.
   - Continue to work with CMHSP supports coordinators in use of SIS in person centered planning.
   - Continue to mature data review and actioning related to addressing needs, significance of support needs, and important to and important for data.
   - Obtain further clarification of completion numbers from MDHHS.
   - Establish a completed assessment tracking system that uses MDHHS' criteria (includes different elements that appear to alter actual numbers).
   - MSHN continued presence at State SIS Steering meetings for information coordination.
   - Continue to ensure proper tracking and progress toward meeting weekly, monthly, and annual assessment targets.
   - Continue to refine quality assurance processes.
   - Enhance tracking and completion of assessments.
   - Initiate new deployment plan for SIS assessors within the region, possibly including a move to one contract.
   - Ensure all first three-year cycle of expected assessments are complete.

ANNUAL REPORT

TEAM NAME: Utilization Management Committee

TEAM LEADER: Todd Lewicki, MSHN UM and Waiver Director

REPORT PERIOD COVERED: 10.1.16 – 9.30.17

Purpose of the Council or Committee: The Utilization Management Committee (UMC) exists to assure effective implementation of the Mid-State Health Network's UM Plan and to support compliance with requirements for MSHN policy, the Michigan Department of Mental Health Prepaid Inpatient Health Plan Contract and related Federal & State laws and regulations.

Responsibilities and Duties: The responsibilities and duties of the UMC include the following:

- Develop and monitor a regional utilization management plan;
- Set utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations;
- Recommend policy and practices for access, authorization and utilization management standards that are consistent with requirements and represent best practices;
- Participate in the development of access, authorization and utilization management monitoring criteria and tools to assure regional compliance with approved policies and standards;
- Support development of materials and proofs for external quality review activities;
- Establish improvement priorities based on results of external quality review activities;
- Recommend regional medical necessity and level of care criteria;
- Review and monitor utilization patterns and analysis to detect and recommend remediation of over/under or inappropriate utilization; and
- Recommend improvement strategies where adverse utilization trends are detected.

Defined Goals, Monitoring, Reporting and Accountability – As defined by the Utilization Management Plan:

1. CMHSP participants shall ensure that the access system staff are qualified, credentialed and trained consistent with the Medicaid Provider Manual, the Michigan Mental Health Code and the MDHHS/PIHP contract.
2. CMHSP participants shall ensure that there is no conflict of interest between the coverage determination and the access to, or authorization of, services.
3. CMHSP participants shall monitor provider capacity to accept new individuals, and be aware of any providers not accepting referrals at any point in time.
4. CMHSP participants shall routinely measure telephone answering rates, call abandonment rates and timeliness of appointment and referrals at any point in time. Any performance issues shall be addressed through the PIHP Quality Assurance and Process Improvement Plan.
5. CMHSP participants shall assure that the access system maintains medical records in compliance with state and federal standards.

6. The CMHSP participants shall work with individuals, families, local communities, and others to address barriers to using the access system, including those caused by lack of transportation.

Annual Evaluation Process:

a. Past Year's Accomplishments: The UMC had ten meetings during the reporting period in that time the following tasks were completed:
   - Successfully implemented the regional Utilization Management Plan:
     - Levels of utilization review
     - Types of specific utilization management measures
     - Change strategy report form
   - Reporting and refinement Mid-State Supplemental Value dataset
   - Continued to formalize the set of UM measures.
   - Refinement of SIS and CAFAS data systems.
   - Creation of a LOCUS data system.
   - Ongoing cross-functional dialogue with QI Council, Clinical Leadership, and Provider Network Management.
   - Use of new decision-agenda that incorporates the schedule of UM reports.
   - Continued use of DataLab group to define and refine UM measures.
   - Expanded SUD reporting in committee.
   -
   - Review of acute level service data and crisis stabilization service need.
   - Decision on data comparisons to review, i.e. per 1,000 population and per 1,000 served.
   - UM discussion relative to prospective, concurrent, and retrospective UM processes.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2018
   - Follow utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations;
   - Recommend policy and practices for access and authorization standards that are consistent with requirements and represent best practices;
   - Ensure representative SUD presence on UMC;
   - Finalize second set of UM measures;
   - Formalization of CAFAS, SIS, and LOCUS in UM systems;
   - Review and monitor utilization patterns and analysis to detect and recommend remediation of over/under or inappropriate utilization;
   - Establish performance improvement priorities identified from monitoring of delegated utilization management functions;
   - Identify opportunities for study and service system strengthening via data and change strategy reporting.
   - Recommend improvement strategies where adverse utilization trends are detected;
   - Recommend opportunities for replication where best practice is identified;
   - Continue to focus on population health measures related to care coordination;
   - Ongoing integration of substance use disorder (SUD) into UM practices;
   - Improve use of MSHN Sharepoint site to disseminate UMC reports and activities.
   - Shift analysis of variance of certain codes to the UM Committee.

- Ensure there is synchronized (as able) content matter expert input into processes shared by UM (i.e. QI, Finance, Clinical, etc.).
- Address succession planning for UM members relative to skill set needed by committee members.
- Input into HCBS data, findings, and system improvements, as appropriate.

SECTION THREE – PERFORMANCE MEASUREMENTS

I. Behavior Treatment Review Reports

Summary Report

Title of Measure: Behavior Review Data

Committee/Department: Quality Improvement Council

Reporting Period (month/year): FY2017-Q4

Data Analysis: (threats to validity; statistical testing; reliability of results; statistical significance; need for modification of data collection strategies)

The study is required by the Michigan Department of Health and Human Services (MDHHS). The data collected is based on the definition and requirements that have been set forth within the Behavioral Technical Requirements attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract.

MSHN delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee (BTRC), including the evaluation of effectiveness of the BTRC by stakeholders. Data will be collected and reviewed quarterly by the CMHSP where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. This data is to be reviewed as part of the CMHSP Quality Improvement Program (QIP) and reported to the PIHP Quality Committee (Quality Assessment and Improvement Program). MSHN monitors that the local CMHSP BTRC follows the requirements outlined within the Technical Requirement for Behavior Treatment Review Committees. MSHN will analyze the data on a quarterly basis to address any trends and/or opportunities for quality improvements. Data shall include numbers of interventions and length of time the interventions were used per person. (MSHN Final Draft Quality Assessment and Performance Improvement Plan, pg. 8)

Data Interpretation: (performance against targets and benchmark data)

Study Question 1: Has the proportion of individuals who have received a restrictive/intrusive intervention decreased over time?

Numerator: The total number of individuals that have an approved behavior treatment plan that include a restrictive and/or intrusive intervention.

Denominator: The total number of individuals who are actively receiving services during the reporting period.

This question reviews the rate per 100 of plans approved with restrictive and intrusive interventions approved per the number of individuals who have been served per quarter. Currently each CMHSP has a process in place to approve all plans which include restrictive and intrusive interventions as required on a quarterly basis.

Currently, MSHN is taking steps to standardize this process by:

- Receiving clarification from MDHHS regarding the actual requirement for the monitoring of the restrictive and intrusive interventions. Clarification has been received, and it was determined that monitoring of restrictive and intrusive interventions should occur at the CMHSP level and not at the PIHP level.
- Participating in the MDHHS Behavioral Treatment Work Group to review the technical requirements attached to the Medicaid Specialty Supports and Services contract.
- Discussing the process at Regional BTRC meetings.
- Identifying and defining standard restrictive and intrusive techniques used consistently throughout MSHN. Most commonly used interventions have been defined for regional use.

FY17Q1

Out of the 12 CMHSP's, 334 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.25% (334/26755) consumers served in the region for FY17Q1 as of December 31, 2016 who have an approved plan for behavior treatment with a restrictive or intrusive intervention.

FY17Q2

Out of the 12 CMHSP's, 309 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.08% (309/28594) consumers served in the region for FY17Q2 as of March 31, 2017 who have an approved plan for behavior treatment with a restrictive or intrusive intervention.

FY17Q3

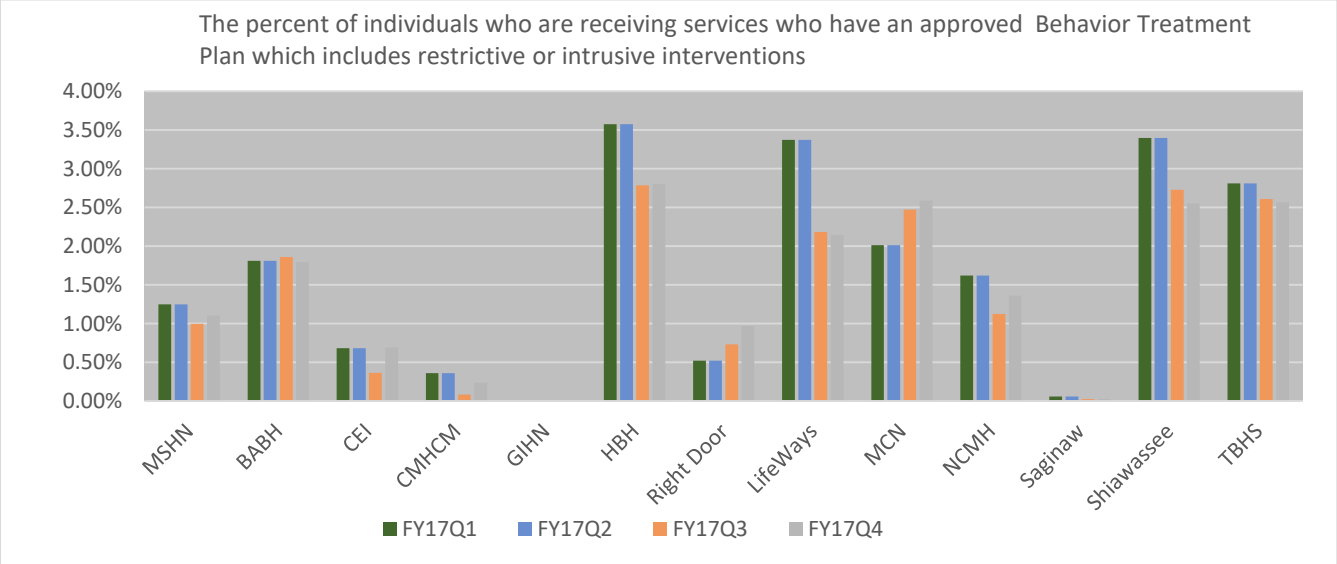
Out of the 12 CMHSP's, 295 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 0.99% (295/29654) consumers served in the region for FY17Q3 as of June 30, 2017 who have an approved plan for behavior treatment with a restrictive or intrusive intervention.

FY17Q4

Out of the 12 CMHSP's, 317 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.1% (317/28687) consumers served in the

region for FY17Q4 as of September 30, 2017 who have an approved plan for behavior treatment with a restrictive or intrusive intervention.

Figure 1



Study Question 2: Has the proportion of individuals who have received physical intervention decreased overtime?

This will be monitored by looking at the numerators and the denominators below.

Numerator: The total number of individuals with whom more than one emergency physical intervention was used during the reporting period.

Denominator: The total number of individuals with whom emergency physical interventions were used during the reporting period.

Numerator: The total number of individuals with whom emergency physical intervention were used during the reporting period.

Denominator: The total number of individuals who are actively receiving services during the reporting period.

FY17Q1

During this reporting period 67 individuals received an emergency physical intervention. A total of 195 emergency physical interventions were used. Less than 1% (.73% -195/26755) of the individuals (Medicaid) served received an emergency physical intervention. This is a slight decrease in the rate per

100 consumers served from the previous reporting period. Of the 67 who received an emergency physical intervention, 24 (36%) individuals received more than one physical intervention. Figure 2 identifies the percent of individuals served who received an emergency physical intervention. Figure 3 demonstrates the number of individuals who received an emergency physical intervention and the number of individuals who received more than 1 emergency physical intervention during the reporting period.

FY17Q2

During this reporting period 51 individuals received an emergency physical intervention. A total of 165 emergency physical interventions were used. Less than 1% (0.58% -165/28594) of the individuals (Medicaid) served received an emergency physical intervention. This is a slight decrease in the rate per 100 consumers served from the previous reporting period. Of the 51 who received an emergency physical intervention, 19 (37%) individuals received more than one physical intervention. Figure 2 identifies the percent of individuals served who received an emergency physical intervention. Figure 3 demonstrates the number of individuals who received an emergency physical intervention and the number of individuals who received more than 1 emergency physical intervention during the reporting period.

FY17Q3

During this reporting period 49 individuals received an emergency physical intervention. A total of 260 emergency physical interventions were used. Less than 1% (0.88% -260/29654) of the individuals (Medicaid) served received an emergency physical intervention. This is a slight decrease in the rate per 100 consumers served from the previous reporting period. Of the 49 who received an emergency physical intervention, 22 (45%) individuals received more than one physical intervention. Figure 2 identifies the percent of individuals served who received an emergency physical intervention. Figure 3 demonstrates the number of individuals who received an emergency physical intervention and the number of individuals who received more than 1 emergency physical intervention during the reporting period.

FY17Q4

During this reporting period 60 individuals received an emergency physical intervention. A total of 155 emergency physical interventions were used. Less than 1% (0.54% 155/28687) of the individuals (Medicaid) served received an emergency physical intervention. This is a slight increase in the rate per 100 consumers served from the previous reporting period. Of the 60 who received an emergency physical intervention, 22 (37%) individuals received more than one physical intervention. Figure 2 identifies the percent of individuals served who received an emergency physical intervention. Figure 3 demonstrates the number of individuals who received an emergency physical intervention and the number of individuals who received more than 1 emergency physical intervention during the reporting period.

Figure 2

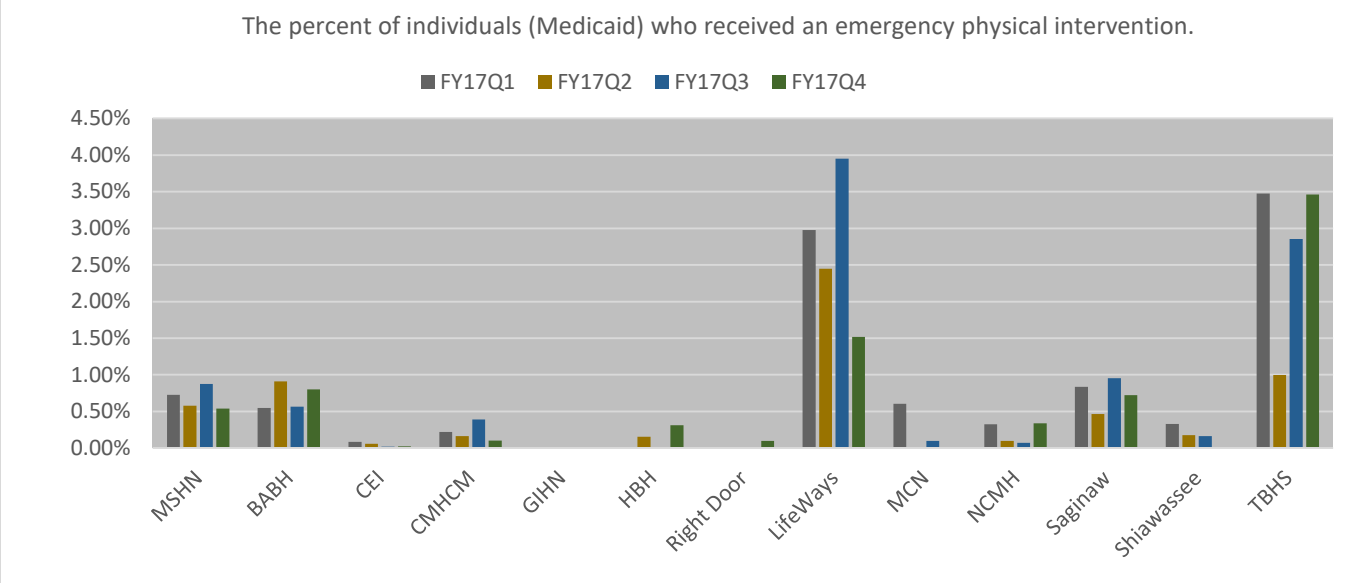


Figure 3

	FY16Q4	FY17Q1	FY17Q2	FY17Q3	FY17Q4
MSHN	**29**	**24**	**19**	**22**	**22**
	60	**67**	**54**	**49**	**60**
BABH	4	4	5	4	4
	7	8	10	8	7
CEI	3	1	0	0	0
	3	3	3	1	1
CMHCM	2	1	1	1	0
	9	8	5	4	6
GCMH	0	0	0	0	0
	0	0	0	0	0
HBH	0	0	0	0	1
	1	0	1	0	1

ICCMH (Right Door)	0	0	0	0	0
	1	0	0	0	1
LifeWays	10	9	9	7	5
	17	26	15	13	19
MCBH	0	1	0	0	0
	2	3	0	1	0
NCMH	1	0	0	0	1
	2	3	1	1	2
Saginaw	6	5	2	6	8
	9	8	10	16	13
Shiawassee	0	0	0	1	0
	2	3	2	1	0
TBHS	3	3	2	3	3
	7	5	4	4	10

The top row for each CMHSP is the number of individuals who received more than one emergency physical intervention during the reporting period. The bottom row is the total number of individuals who received an emergency physical intervention during the reporting period.

FY17Q1

One hundred and ninety-five (195) emergency physical interventions were used during FY17Q1 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. An increase was noted for the use of all physical interventions with the exception of the transport/escort that showed a slight decrease from the previous quarter. According to the distribution of interventions, the Wrap Hold category continued to have the highest percentage of interventions.

FY17Q2

One hundred and sixty-five (165) emergency physical interventions were used during FY17Q2 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. A slight increase was noted for the use of the supine hold, transport/escort and other/unidentified and a slight decrease in the use of the wrap hold and a more significant decrease for the use of the hands down hold from the previous quarter. According to the distribution of interventions, the Wrap Hold category continued to have the highest percentage of interventions.

FY17Q3

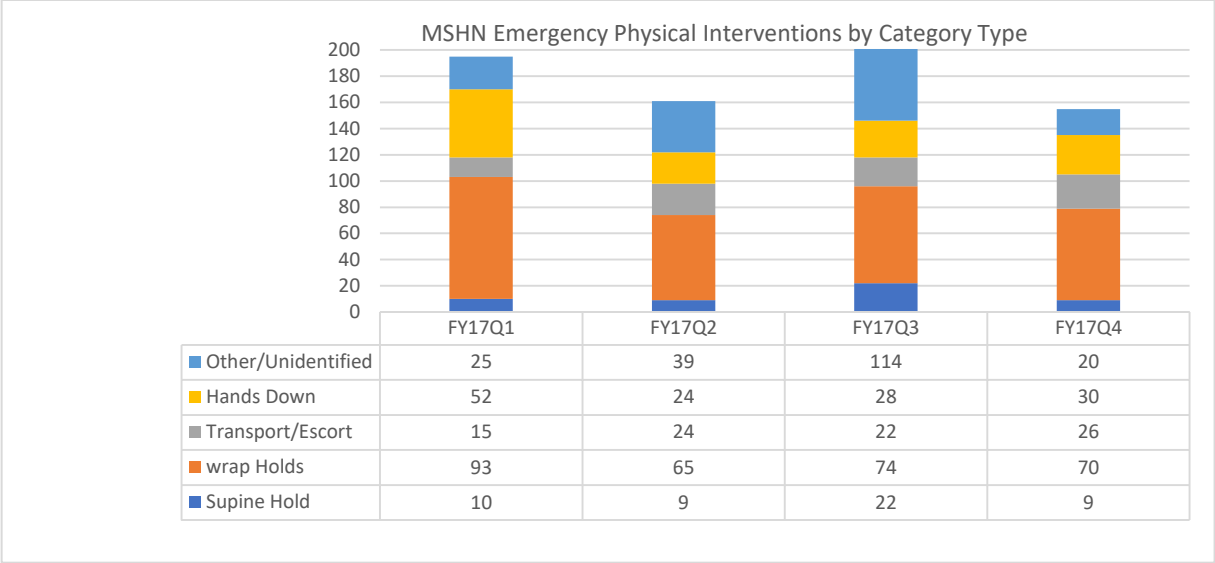
Two hundred and sixty (260) emergency physical interventions were used during FY17Q3 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. A slight increase was noted for the use of the supine hold and other/unidentified and a slight decrease in the use of transport/escort, the wrap hold and hands down hold from the previous quarter. According to the distribution of interventions, during this quarter, the other/unidentified category had the highest percentage of use.

FY17Q4

One hundred and fifty-five (155) emergency physical interventions were used during FY17Q4 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. A slight decrease was noted for the use of the supine hold and wrap hold and a significant decrease was noted for the category of other/unidentified. A slight increase was noted for the use of transport/escort and hands down hold from the previous quarter. According to the distribution of interventions, during this quarter, the wrap hold category had the highest percentage of use.

Figure 4

Physical Intervention	**FY17 Q1**	**FY17Q2**	**FY17Q3**	**FY17Q4**
Supine Hold	(10) 5%	(9) 6%	(22) 8%	(9) 6%
Wrap Hold (wrap around hold, CPI team hold, NAPPI capture wrap, standing wrap, seated wrap, body hug, basket wrap, 1-2 stability hold, chair stability hold)	(93) 48%	(65) 40%	(74) 28%	(70) 45%
Transport/Escort (come along, CPI Transport, primary escort, 2 person escort, modified transport)	(15) 8%	(24) 15%	(22) 8%	(26) 17%
Hands down with resistance	(52) 27%	(24) 15%	(28) 11%	(30) 19%
Other/Unidentified	(25) 13%	(43) 26%	(114) 44%	(20) 13%
MSHN Total	(195) 100%	(165) 100%	(260) 100%	(155) 100%



	FY17Q1	FY17Q2	FY17Q3	FY17Q4
Other/Unidentified	25	39	114	20
Hands Down	52	24	28	30
Transport/Escort	15	24	22	26
wrap Holds	93	65	74	70
Supine Hold	10	9	22	9

The length of time for the interventions was based on each individual intervention. It was agreed by the BTRC/QI Council that the length of time will be reported based on time intervals of ≤ 5 minutes, 6-10 minutes, and 11-15 minutes. This process for reporting will become standardized over the next year. Figure 5 identifies the number of interventions and the length of time for each, 1 were reported to be outside of the 15-minute window, and 5 were reported as unknown. Follow up regarding the unreported and reported outside of the window is being completed at each CMHSP to ensure a process is in place to collect the length of time for each intervention.

Figure 5

Length of time of intervention	**FY17Q1**	**FY17Q2**	**FY17Q3**	**FY17Q4**
The total number of interventions within this time frame ≤ 5 minutes	95	70	110	81
The total number of interventions within this time frame 6-10 minutes	30	21	34	30
The total number of interventions within this time frame 11-15 minutes	17	32	37	23

Study Question 3: Has the proportion of incidents in which police have been called for assistance by staff to manage a behavioral incident decreased?

Numerator: The total number of incidents requiring phone calls made by staff to police for behavioral assistance.

Denominator: The total number of individuals who are actively receiving services during the reporting period.

FY17Q1

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY17Q1 was .19% (50/26755). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY17Q1 was 50. Seven CMHSP Participants utilized police assistance during this reporting period. This was a decrease in the number of CMHSPs who utilized the police for behavioral assistance in the previous quarter. It should be noted that police interventions are used primarily for individuals with a mental illness.

FY17Q2

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY17Q2 was .30% (87/28594). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY17Q2 was 87. Seven CMHSP Participants utilized police assistance during this reporting period. This was the same number of CMHSPs who utilized the police for behavioral assistance in the previous quarter. It should be noted that police interventions are used primarily for individuals with a mental illness.

FY17Q3

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY17Q3 was .27% (79/29654). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY17Q3 was 79. Seven CMHSP Participants utilized police assistance during this reporting period. This was the same number of CMHSPs who utilized the police for behavioral assistance in the previous quarter. It should be noted that police interventions are used primarily for individuals with a mental illness.

FY17Q4

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY17Q4 was .25% (73/28687). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY17Q4 was 73. Six CMHSP Participants utilized police assistance during this reporting period. This was a decrease by one CMHSP who utilized the police for behavioral assistance in the previous quarter. It should be noted that police interventions are used primarily for individuals with a mental illness.

Figure 6

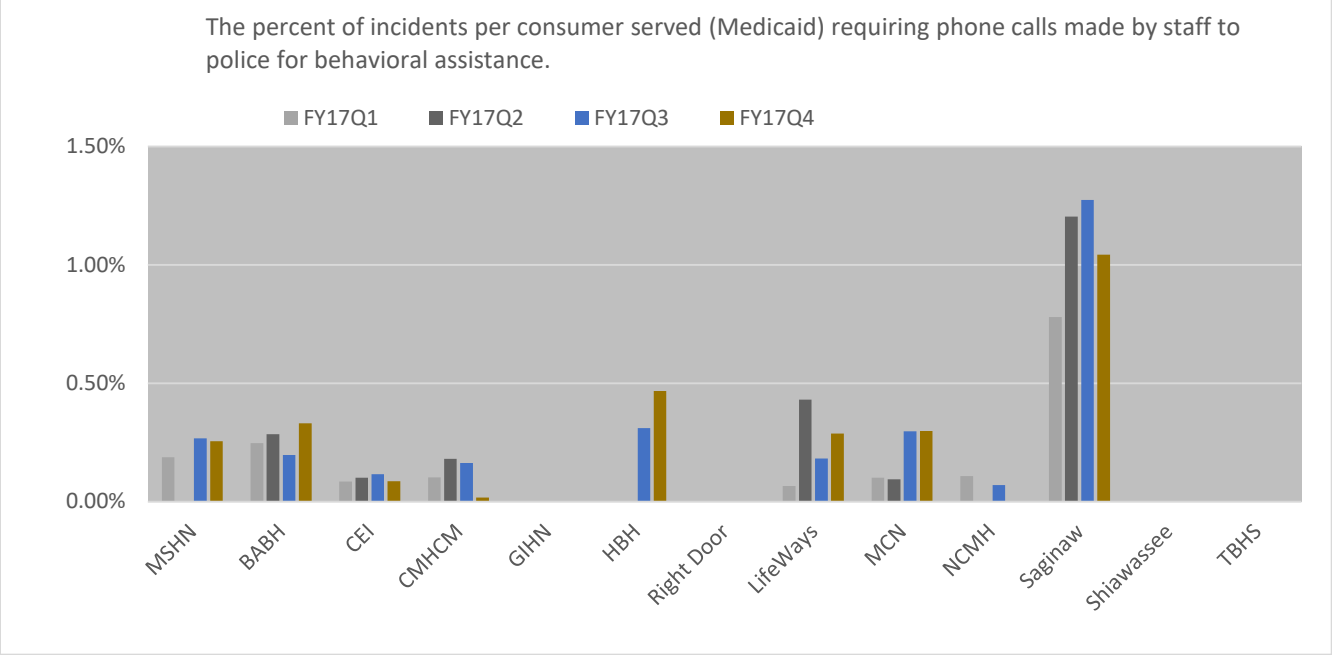
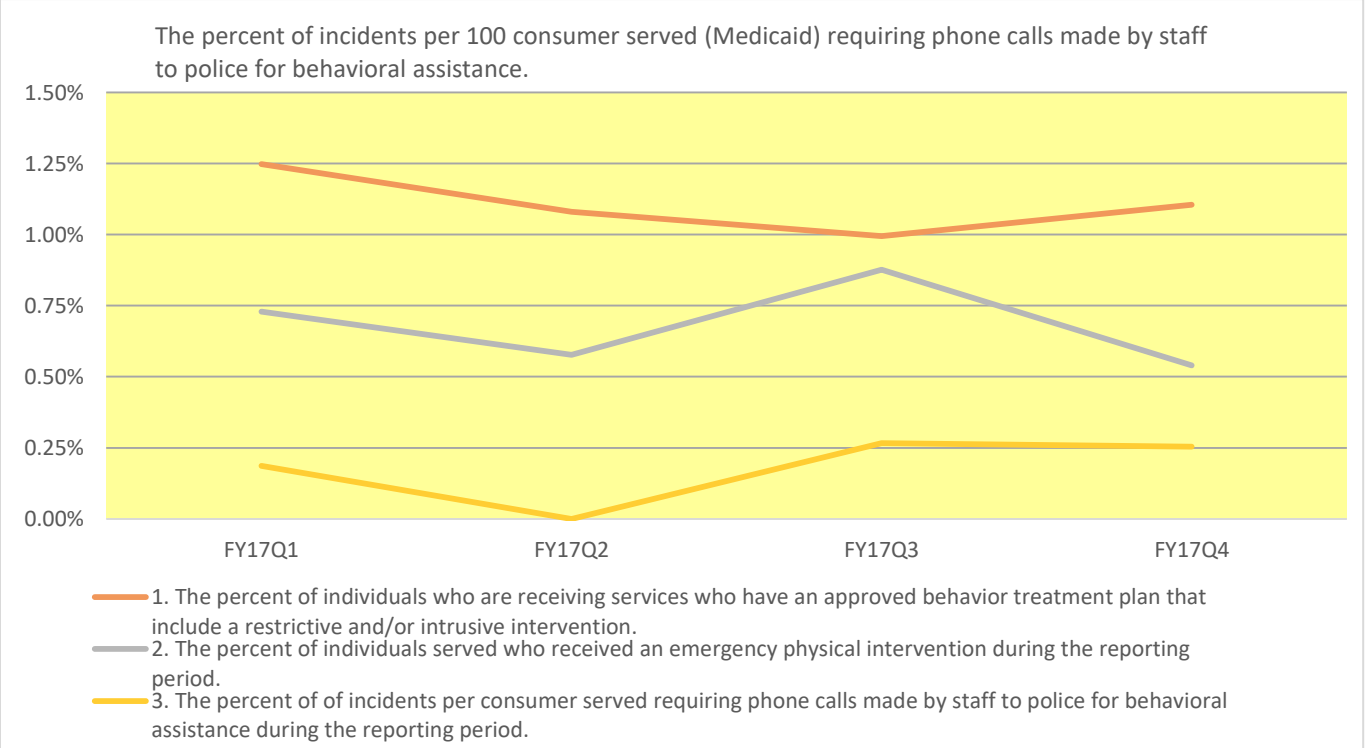


Figure 7



Conclusions:

Study Question 1: Has the proportion of individuals who have received a restrictive/intrusive intervention decreased over time? 1.44% (FY14Q2) compared to 1.1% (FY17Q4) of the individuals served have a Behavior Treatment Plan with Intrusive and/or Restrictive Interventions. This indicates that the proportion is lower than first reported in FY14Q2. The percentage varied between FY14Q3 through FY16Q4, showing slight increases and decreases between quarters. FY17Q1 through FY17Q3 showed a slight decrease each quarter. Then FY17Q4 showed a slight increase from the previous quarter.

Study Question 2: Has the proportion of individuals who have received physical intervention decreased overtime? .53% (FY14Q2) compared to .54% (FY17Q4) have received an emergency physical intervention. This shows a slight increase over time. The PIHP has developed consistent definitions and reporting mechanisms that have assisted with the accuracy of the reporting. There had been an upward trend in the data beginning FY14Q3 through FY15Q2. Then beginning in FY15Q3 a downward trend started and went through FY16Q1. FY16Q2 through FY17Q3 has shown fluctuations between increasing and decreasing. FY17Q4 showed a decrease from the previous quarter. This will continue to be monitored as to any factors that may be causing an increase.

Study Question 3: Has the proportion of incidents in which police have been called for assistance by staff to manage a behavioral incident decreased? .32% (FY14Q2) compared to .25% (FY17Q4) indicates a slight decrease in the proportion of incident in which the police have been called for police assistance with a behavioral incident over time. During the time this has been monitored, the overall percentage has been trending downward with some quarters fluctuating and showing slight increases.

Observation: FY17Q4 showed a slight increase from FY17Q3 in the percentage of individuals served who received an emergency physical intervention, but showed a slight decrease in the percentage of phone calls made to police for behavioral assistance. For FY17Q4, the number of individuals who had an approved behavior treatment plan that included a restrictive and/or intrusive intervention was 317 which was an increase from FY17Q3 which was at 295. Overall, FY17Q4 reported good percentages, showing a slight decrease from FY17Q3 in two of the three areas being monitored.

Improvement Strategies:

Continue to monitor the number of plans. Monitor to see if there is a correlation between the number of plans decreasing and the number of phone calls to police or emergency physical interventions increasing.

It is recommended that a review of the reported emergency interventions occur to identify the time frames of any unreported time frames of the emergency physical interventions and the factors for the interventions to be longer than 15 minutes.

To continue to monitor the rate of phone calls to Police for staff assistance for each CMHSP. Each CMHSP should review for any trends with particular settings, explore alternative interventions, and take appropriate action to decrease as necessary without affecting the safety of the staff, community or the individuals served.

It is also recommended that each CMHSP ensure that interpretations and definitions are consistent across the region. CMHSPs will continue to work on reporting accuracies consistent with MSHN.

Analysis by: Kim Zimmerman
Director of Customer Service, Compliance and QI

Date: November 2017

MSHN QIC Approved: November 16, 2017

II. Critical Incident Reports

MSHN Quarterly Critical Incident Report (FY 2017)

Data Submission Date: 10/31/17

Board	Incident Type	Quarter 1 Totals (Oct-Dec)	Quarter 2 Totals (Jan-Mar)	Quarter 3 Totals (Apr-Jun)	Quarter 4 Totals (Jul-Sep)	FY Total (Oct-Sep)	FY Incidents Per 1000 Residents
Bay Arenac Behavioral Health	Suicide	1	0	0	1	2	0.0164
	Non-Suicide Death	8	10	9	5	32	0.2616
	EMT due to Injury/Medication Error	8	13	9	10	40	0.3270
	Hospitalization due to Injury/Medication Error	1	1	0	0	2	0.0164
	Arrest	0	0	1	0	1	0.0082
Census: 122,319	**Total**	**18**	**24**	**19**	**16**	**77**	**0.6295**
CMH Central Michigan	Suicide	0	0	1	0	1	0.0036
	Non-Suicide Death	10	8	3	10	31	0.1120
	EMT due to Injury/Medication Error	33	38	39	25	135	0.4877
	Hospitalization due to Injury/Medication Error	1	2	2	1	6	0.0217
	Arrest	4	4	3	1	12	0.0434
Census: 276,784	**Total**	**48**	**52**	**48**	**37**	**185**	**0.6684**
CMHA CEI	Suicide	0	1	1	0	2	0.0043
	Non-Suicide Death	16	10	16	14	56	0.1198
	EMT due to Injury/Medication Error	8	8	6	6	28	0.0599
	Hospitalization due to Injury/Medication Error	0	1	1	0	2	0.0043
	Arrest	0	0	2	0	2	0.0043
Census: 467,321	**Total**	**24**	**20**	**26**	**20**	**90**	**0.1926**

Board	Incident Type	Quarter 1 Totals (Oct-Dec)	Quarter 2 Totals (Jan-Mar)	Quarter 3 Totals (Apr-Jun)	Quarter 4 Totals (Jul-Sep)	FY Total (Oct-Sep)	FY Incidents Per 1000 Residents
Gratiot CMH **Census: 41,968**	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	2	1	3	0	6	0.1430
	EMT due to Injury/Medication Error	2	0	0	0	2	0.0477
	Hospitalization due to Injury/Medication Error	1	0	1	0	2	0.0477
	Arrest	0	0	0	0	0	0.0000
	Total	**5**	**1**	**4**	**0**	**10**	**0.2383**
Huron Behavioral Health **Census: 32,224**	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	0	1	3	1	5	0.1552
	EMT due to Injury/Medication Error	0	0	0	0	0	0.0000
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
	Arrest	0	0	0	0	0	0.0000
	Total	**0**	**1**	**3**	**1**	**5**	**0.1552**
The Right Door (Ionia CMH) **Census: 64,073**	Suicide	1	0	1	1	3	0.0468
	Non-Suicide Death	2	4	1	1	8	0.1249
	EMT due to Injury/Medication Error	0	1	1	0	2	0.0312
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
	Arrest	2	4	1	0	7	0.1093
	Total	**5**	**9**	**4**	**2**	**20**	**0.3121**
Lifeways **Census: 206,470**	Suicide	0	0	0	7	0	0.0000
	Non-Suicide Death	10	15	7	0	39	0.1889
	EMT due to Injury/Medication Error	5	1	5	0	11	0.0533
	Hospitalization due to Injury/Medication Error	2	2	0	1	4	0.0194
	Arrest	0	1	0	8	2	0.0097
	Total	**17**	**19**	**12**	**12**	**56**	**0.2712**

Board	Incident Type	Quarter 1 Totals (Oct-Dec)	Quarter 2 Totals (Jan-Mar)	Quarter 3 Totals (Apr-Jun)	Quarter 4 Totals (Jul-Sep)	FY Total (Oct-Sep)	FY Incidents Per 1000 Residents
Montcalm Behavioral Health **Census: 63,105**	Suicide	0	0	0	1	1	0.0158
	Non-Suicide Death	0	3	2	1	6	0.0951
	EMT due to Injury/Medication Error	8	3	6	9	26	0.4120
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
	Arrest	3	2	0	2	7	0.1109
	Total	**11**	**8**	**8**	**13**	**40**	**0.6339**
Newaygo CMH **Census: 48,001**	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	3	1	1	3	8	0.1667
	EMT due to Injury/Medication Error	0	6	0	1	7	0.1458
	Hospitalization due to Injury/Medication Error	0	1	0	0	1	0.0208
	Arrest	1	0	1	0	2	0.0417
	Total	**4**	**8**	**2**	**4**	**18**	**0.3750**
Saginaw CMH **Census: 196,542**	Suicide	0	0	1	0	1	0.0051
	Non-Suicide Death	5	11	8	11	35	0.1781
	EMT due to Injury/Medication Error	15	21	23	19	78	0.3969
	Hospitalization due to Injury/Medication Error	1	1	2	3	7	0.0356
	Arrest	1	0	0	3	4	0.0204
	Total	**22**	**33**	**34**	**36**	**125**	**0.6360**
Shiawassee CMH **Census: 68,900**	Suicide	0	0	0	1	1	0.0145
	Non-Suicide Death	0	8	4	3	15	0.2177
	EMT due to Injury/Medication Error	3	1	2	7	13	0.1887
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
	Arrest	0	0	0	0	0	0.0000
	Total	**3**	**9**	**6**	**11**	**29**	**0.4209**

Board	Incident Type	Quarter 1 Totals (Oct-Dec)	Quarter 2 Totals (Jan-Mar)	Quarter 3 Totals (Apr-Jun)	Quarter 4 Totals (Jul-Sep)	FY Total (Oct-Sep)	FY Incidents Per 1000 Residents
Tuscola BH Systems	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	2	1	0	0	3	0.0553
	EMT due to Injury/Medication Error	5	9	4	3	21	0.3870
	Hospitalization due to Injury/Medication Error	1	0	0	0	1	0.0184
Census: 54,263	Arrest	1	0	1	1	3	0.0553
	Total	**9**	**10**	**5**	**4**	**28**	**0.5160**
MSHN TOTALS	Suicide	2	1	4	4	11	0.0067
	Non-Suicide Death	58	73	57	56	244	0.1486
	EMT due to Injury/Medication Error	87	101	95	80	363	0.2211
	Hospitalization due to Injury/Medication Error	7	8	6	4	25	0.0152
Census: 1,641,970	Arrest	12	11	9	8	40	0.0244
	Total	**166**	**194**	**171**	**152**	**683**	**0.4160**

III. Medicaid Event Verification Report

Pre-Paid Inpatient Health Plan

Medicaid Services Verification Methodology Report

Fiscal Year 2017

(October 1, 2016 – September 30, 2017)

Methodology Report Outline

Introduction & Background

Process/Methodology Summary

Summary of Results

A. Summary of Analysis
B. Study Results
C. Data Chart

Deficiencies/Plans of Correction

A. Fiscal Year 2017 Deficiencies
B. Repeated Deficiencies

Process/Performance Improvement

Future Outlook

Introduction & Background

In accordance and compliance with the Medicaid Managed Specialty Supports and Services Contract[1], Mid-State Health Network (MSHN) submits the Medicaid Event Methodology Report that summarizes the verification activities across the PIHP region. The region includes twelve (12) Community Mental Health Specialty Program (CMHSP) participants; Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Services Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Huron Behavioral Health, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health, Saginaw County Community Mental Health Authority, Shiawassee County Community Mental Health Authority, The Right Door, and Tuscola Behavioral Health Systems. Also within the PIHP region are 60 substance use disorder (SUD) treatment providers that include 14 treatment providers that have multiple service locations and 35 agencies that provide prevention services.

MSHN conducts oversight of the Medicaid claims/encounters submitted within the region by completing an onsite review of the provider networks policy and procedures and the claims/encounters submitted for services provided for all 12 of the CMHSPs and for all substance use disorder treatment providers who provide services using Medicaid funding. Of the 60 SUD treatment providers, only the 33 providers that provided Medicaid eligible services and used Medicaid funding were included in the review. The 33 providers included 57 unique service provider locations. SUD disorder treatment providers that were in another PIHP region and had a MEV review completed in that region were not included in the MEV summary.

Process Summary/Sampling Methodology

Medicaid claims verifications are conducted bi-annually (twice a year) for CMHSPs and annually (once a year) for substance use providers, utilizing a random sample. Sample selection for the CMHSP includes both the direct services provided by the CMHSP and the services provided at a contract provider of the CMHSP. Substance use providers with multiple locations with distinct site licenses had a sample reviewed for each location.

The random sample is selected using a non-duplicated sample of 5% of beneficiaries served in the previous 2 quarters. The sample selection is set with parameters not to exceed a maximum of 50 and a minimum of 20 beneficiaries. The number of claims/encounters for each beneficiary selected in the sample has a maximum of 50 claims/encounters per beneficiary.

The sample selection for CMHSPs includes at least one beneficiary from each of the following programs; Assertive Community Treatment (ACT), Autism, Crisis Residential, Home Based Services, Habilitation Supports Waiver (HSW), Self Determination, Targeted Case Management (TCM)/Supports Coordination Services, and Wraparound. Substance Use Provider samples

[1] Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 16 – Attachment P.6.4.1

consisted of at least one beneficiary from each of the following service types as applicable to the provider; Detox, Residential, Out-Patient Services, and Medication Assisted Treatment.
The sample is pulled using Microsoft Sequel Server and Excel. Microsoft Server Sequel will use program scripts to pull the beneficiaries served during the previous two quarters from the MSHN Data Warehouse. Every beneficiary will then be assigned a random number within Excel. An additional column will then be created within Excel and the formula "=rand()" will then be used to select the random 6% of beneficiaries. Only the top 5 % of beneficiaries will be used to complete the sample for the review if all the required program types are met. If the sample does not include one beneficiary from each required program type the last beneficiary will be removed from the 5% sample and the next beneficiary on the sample list that meets the criteria will be used. If all the program types are not met with the 6% sample pulled, then the process will be run again to select additional beneficiaries. This will be done until all the required program types are selected.

The summary incorporates services that are documented in the CMHSP electronic health record and those services not documented in the EHR (paper charts and/or contracted providers).

Data Analysis/Summary of Results

Summary of Analysis

Records and claims were reviewed over the course of the full fiscal year, October 1, 2016 – September 30, 2017. Data presented in the below chart is relative to the 12 CMHSP's and 33 substance use disorder treatment providers (representing 57 unique service provider locations) reviewed during this period. It is noted that to align the Medicaid Event Verification review with the Delegated Managed Care review, that is completed annually by the PIHP, some CMHSP dates were moved resulting in 6 of the CMHSPs having 3 Medicaid Event Verification reviews during the fiscal year 2017.

The attributes tested during the Medicaid Event Verification review include: A.) The code is allowable service code under the contract, B.) Beneficiary is eligible on the date of service, C.) Service is included in the beneficiary's individual plan of service, D.) Documentation of the service date and time matches the claim date and time of the service, E.) Documentation of the service provided falls within the scope of the service code billed, F.) Amount billed and paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the HCPCS guidelines.

A 90% compliance standard is the expectation per the state technical requirement for Event Verification.

CMHSP

	A	B	C	D	E	F	G
BABHA*	100	100	98.95	97.70	97.36	100	96.52
CEI	100	100	98.15	90.39	87.02	100	100
CMHCM	100	100	98.90	99.22	87.15	100	96.68
Gratiot*	100	100	96.27	89.83	93.00	99.80	99.64
Huron*	100	100	99.41	98.99	95.71	99.93	99.60
Lifeways*	100	100	99.95	97.95	97.41	100	98.78
Montcalm	100	100	99.01	91.06	89.21	100	99.55
Newaygo	100	100	94.10	97.47	98.27	100	99.74
Saginaw*	100	100	99.95	97.19	97.30	100	98.82
Shiawassee*	100	100	99.88	97.56	97.83	100	100
The Right Door	100	100	100	97.95	91.48	100	98.09
Tuscola	100	100	99.50	98.23	99.44	100	99.11
MSHN Average	**100%**	**100%**	**98.67%**	**96.13%**	**94.27%**	**99.98%**	**98.88%**

Note: A) The code is allowable service under the contract, B) Beneficiary is eligible on the date of service, C) Service is included in the persons individualized plan of service, D) Documentation of the service date and time matches the claim date and time of the service, E.) Documentation of the service provided falls within the scope of the service code billed, F.) Amount billed and paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the HCPCS guidelines.

*Indicates a CMHSP that had three (3) Medicaid Event Verification Reviews during the fiscal year 2017.

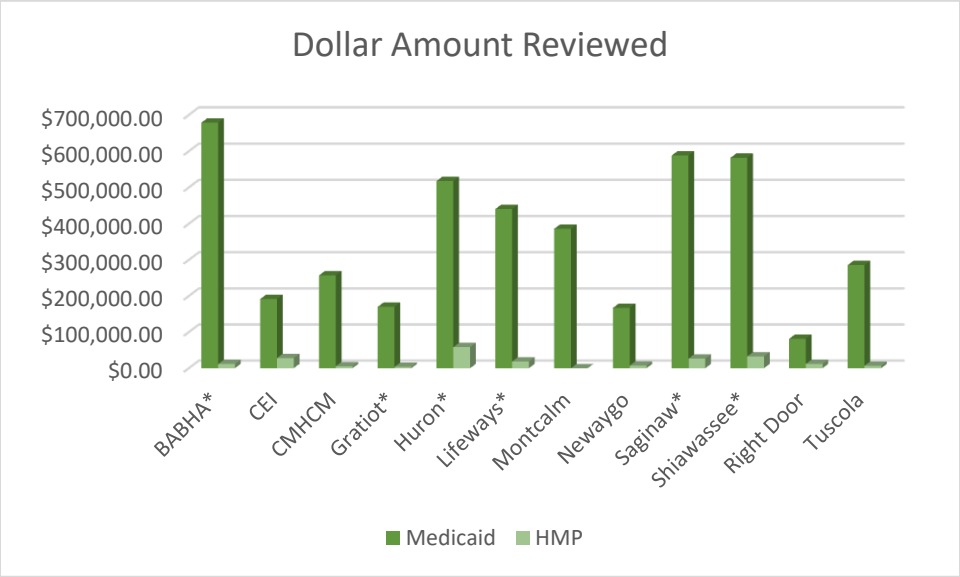
SUD

	A	B	C	D	E	F	G
SUD Providers	**100%**	**97.75%**	**91.04%**	**93.22%**	**93.93%**	**100%**	**97.01%**

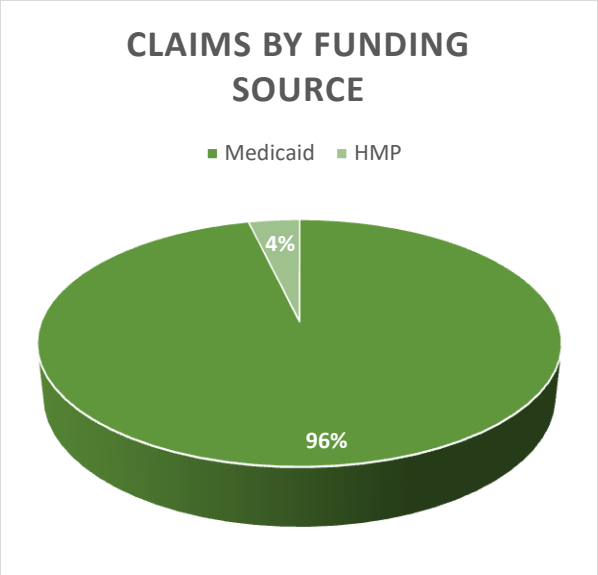
Summary of CMHSP Claims Reviewed by Funding Source:

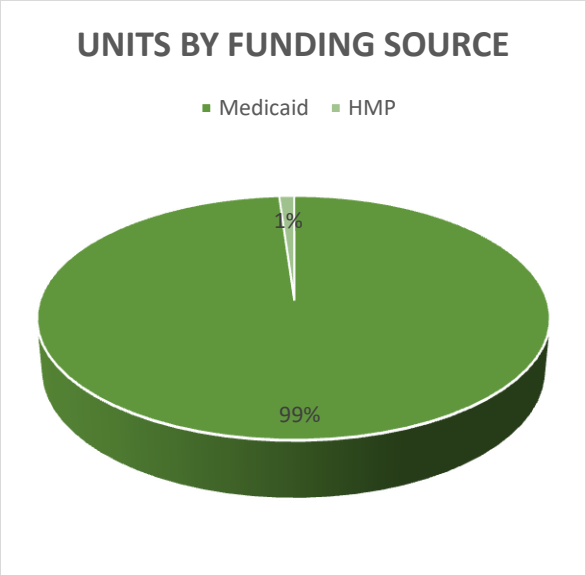
In total 19,560 claims were reviewed. Of the 19,560 claims reviewed 18,834 of the claims were billed as Medicaid and 726 of the claims were billed using Healthy Michigan Plan Funding. The 19,560 claims included 179,200 units of service. Of the 179,200 units reviewed 177,251 were billed as Medicaid and 1,949 were billed as Healthy Michigan Plan. The dollar amount of the claims reviewed totaled $4,419,663.60. Of the $4,419,663.60 reviewed $4,345,894.80 were billed using Medicaid funding and $210,279.89 were billed using Healthy Michigan funding.

Note: Montcalm Care Network did not have any claims reviewed that were billed as Healthy Michigan Plan.



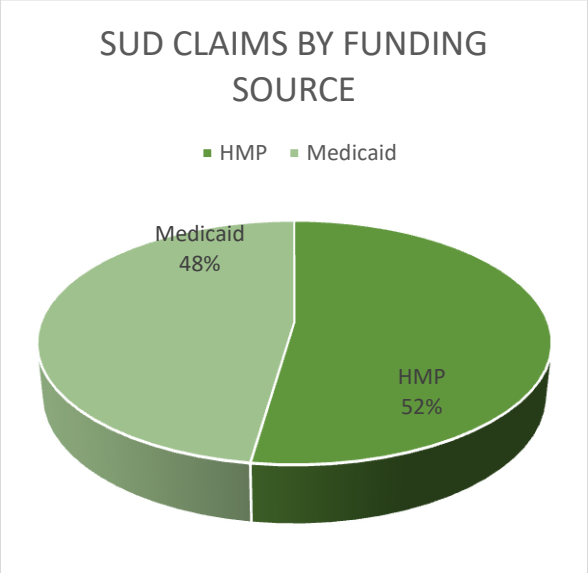
*Indicates a CMHSP that had three (3) Medicaid Event Verification Reviews during the fiscal year 2017.

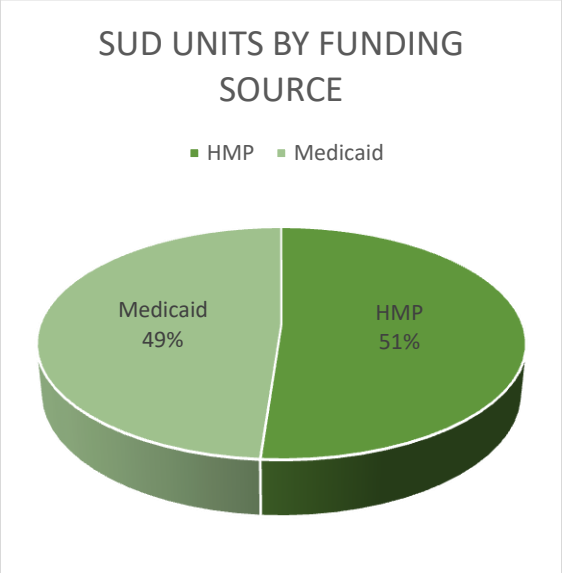




Summary of SUD Claims Reviewed by Funding Source:

In total 18,265 claims were reviewed. Of the 18,265 claims reviewed 8,711 of the claims were billed as Medicaid and 9,554 of the claims were billed using Healthy Michigan Plan Funding. The 18,265 claims included 30,011 units of service. Of the 30,011 units reviewed 14,656 were billed as Medicaid and 15,355 were billed as Healthy Michigan Plan. The dollar amount of the claims reviewed totaled $1,499,459.89. Of the $1,499,459.89 reviewed $653,917.16 were billed using Medicaid funding and $848,232.73 were billed using Healthy Michigan funding.





The services reviewed for the CMHSPs were from ACT, autism, crisis residential, homebased, HAB waiver, self-determination, targeted case management and supports coordination, and wraparound. As some people were enrolled in more than one program and services were counted in more than one program, the overall total of claims/encounters do not match the claims/encounters total from the total by funding source. The program total is based on program enrollment and not by independent service provided such as assessments, outpatient, treatment plan reviews, and medication reviews.

CMHSP Services Reviewed by Program			
Program	**Claims**	**Units**	**Amount**
ACT	2,936	8,915	$546,959.64
Autism	947	4,403	$144,843.78
Crisis Residential	189	241	$99,762.53
Habilitation Supports Waiver	6,911	82,326	$2,005,432.40
Home Based Services	2,069	10,906	$594,033.77
Self Determination	5,256	91,787	$533,565.55
Targeted Case Management and Supports Coordination	3,301	13,830	$755,987.93
Wraparound	474	2,110	$162,126.91

The services reviewed for the SUD provider were from detox and residential, outpatient, peer delivered services, and medication assisted treatment. As some people were enrolled in more than one program and services were counted in more than one program the overall total of claims/encounters do not match the claims/encounters total from the total by funding source. The program total is based on program enrollment and not by independent service provided such as assessments, psychotherapy, treatment plan reviews, and medication reviews.

SUD Services Reviewed by Program			
Program	Claims	Units	Amount
Detox/Residential	6,523	7,000	$955,941.55
Medication Assisted Treatment	5,141	5,391	$101,154.00
Outpatient	11,527	22,796	$528,525.82
Peer Services	103	103	$4,120.00

Deficiencies/Corrective Action

Fiscal Year 2017 Deficiencies

MSHN requires deficiencies found during the Medicaid Event Verification process be resolved immediately through one or more of the following methods:

- Billing records re-billed with correct information (e.g. code change, funding source change);
- Billed services in error voided;
- Person centered plans updated with correct authorization; and
- Reduction to future payments on subcontractor claims as necessary

For deficiencies found as a system issue, network providers are required to document a corrective action plan and demonstrate sufficient monitoring and oversight to ensure implementation. Corrective action plans may consist of education and training, data software system changes, and process changes along with related expected timelines for implementation.

MSHN reviews and monitors the corrective action plans during the following review cycle to ensure implementation of the plan indicated. For substance use disorder providers, the claims/encounters are voided immediately by MSHN for any claims/encounters determined to be invalid. The CMHSPs complete their own corrections and voids for claims/encounters found to be invalid and MSHN reviews to ensure this has been completed correctly. If deemed necessary by MSHN, additional follow up and sampling of selected elements is completed to ensure system and process change.

Based on the MEV review for FY2017, 12 CMHSPs were placed on a new plan of correction and 53 substance use disorder treatment provider locations were placed on a new plan of correction. 12 CMHSPs were removed from a previous plan of correction and 33 substance use disorder treatment provider locations were removed from a previous plan of correction. There were 15 substance use provider locations that had a repeat issue identified in the corrective action plan.

The overall findings included a total of 4,183 claim lines identified as invalid claims/encounters based on one or more of the established review criteria. This included a total of 30,278 units of service and a total dollar amount of $479,822.92. Of the invalid claims/encounters, 1,780 claim lines of service were from reviews of CMHSPs direct and indirect services and 2,403 claim lines were from substance use disorder treatment providers. The total of invalid units included 25,595 units of service from CMHSPs and 4,683 units of service from substance use disorder providers. The total dollar amount of invalid claims identified included $322,953.22 for CMHSPs and $156,869.70 for substance use disorder treatment providers. All invalid claims were corrected based on MSHN's established process.

NOTE: Many of the invalid claims related to documentation was due to a lack of understanding what documentation was needed to support the claims. In these instances, additional documentation was sent with the plan of correction to justify the claims originally found to be invalid. These units and dollars are included in the summary of disallowed amounts as they were original findings that documentation did not support during the review.

If suspicion of fraud or abuse was apparent, the CMHSPs were required to report to MSHN for further review and follow up. As part of MSHN's ongoing compliance process, MSHN completes an initial investigation to determine if reporting to MDHHS and/or the Office of Health Service Inspector General is required. This process occurs throughout the year as the reports are received.

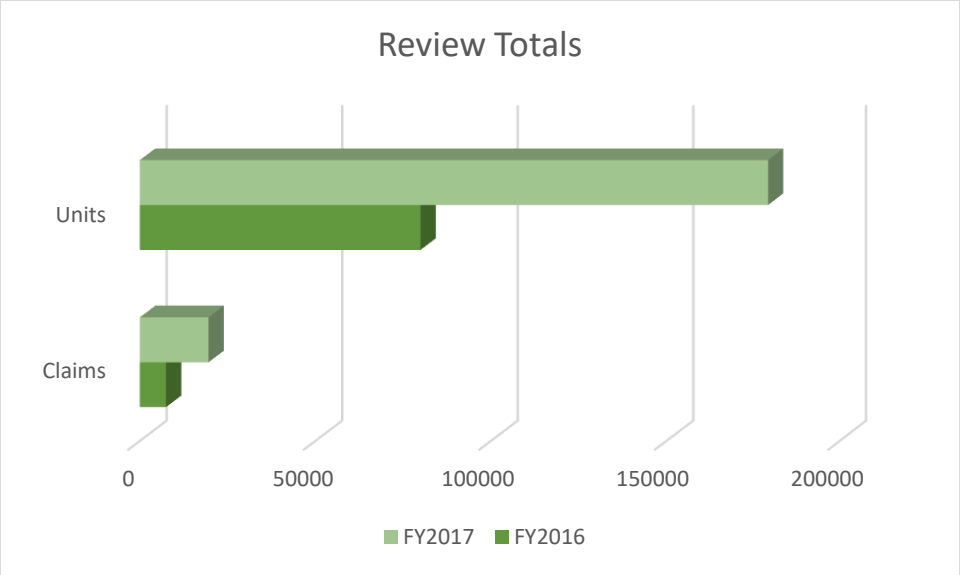
Repeated Deficiencies

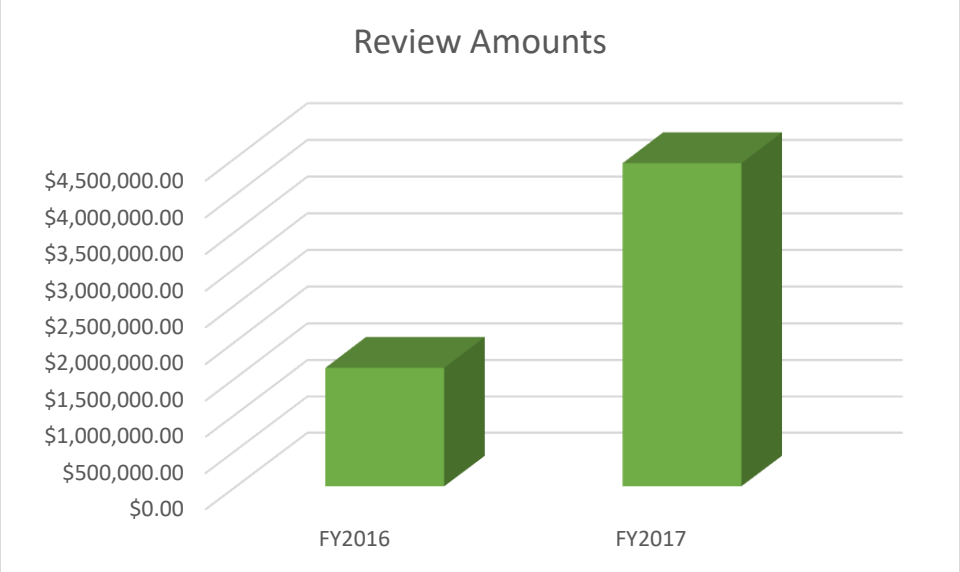
Though the MSHN average for CMHSPs and SUD providers did not fall below the departments 90% accuracy rate for any area reviewed, there were providers that had elements tested that fell below the 90% accuracy standard.

A review of the elements tested from the MEV reviews completed at each CMHSP and SUD provider during FY2016 and FY2017 indicated there were repeated deficiencies at three (3) CMHSPs and two (2) SUD providers. The deficiencies for the CMHSPs were related to documentation of the service provided not falling within the scope of the service code billed. The deficiencies for the SUD providers included having documentation of the service provided not falling within the scope of the service code billed and modifiers being used incorrectly.

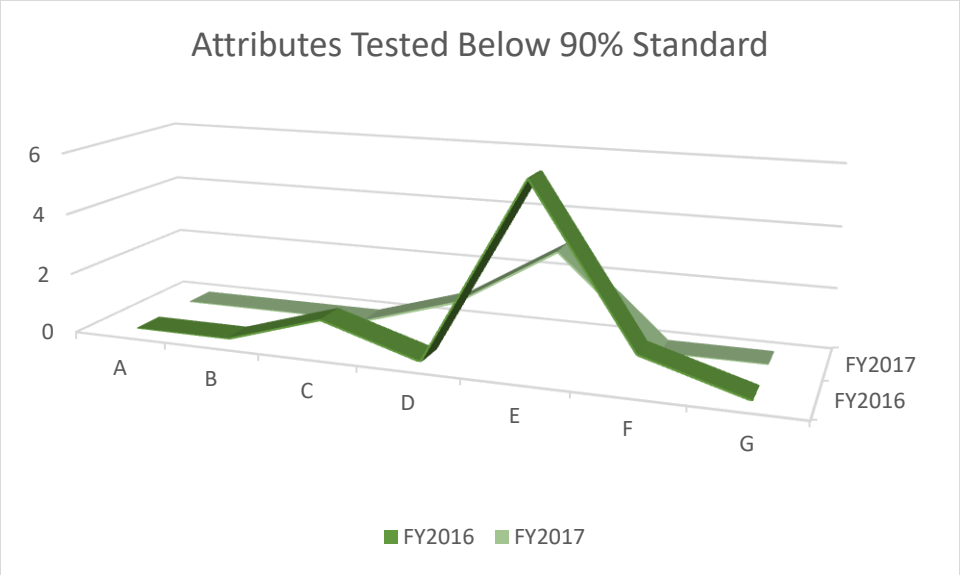
Process/Performance Improvement

Process Improvements:
Process improvements implemented from previous MEV Reviews are related to doubling the number of claims reviewed, units reviewed, and the total dollar amount reviewed from FY2016 to FY2017.

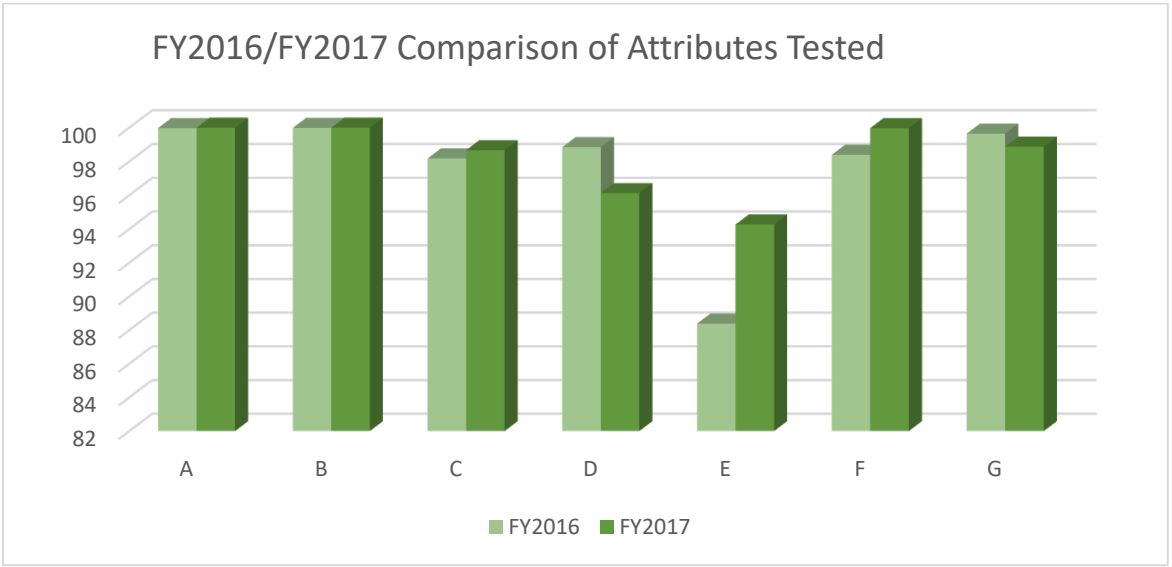




Performance Improvements:
Additionally, during FY2016 there were 7 CMHSP's with at least one element tested that fell beneath the 90% accuracy standard. During FY2017 this was reduced to 4 CMHSPs with at least one element below the 90% accuracy standard.



While there were some common findings for the CMHSPs that were identified during both the MEV reviews that included the lack of documentation for per diem and 15-minute community living supports, personal care, and skill building, there was improvement shown from FY2016 to FY2017 for elements A, B, C, E, and F. This was a result of improvements put into place by many of the providers, that included the creation of new documentation standards/forms following the FY2016 review process. There was also improvement shown from FY2016 to FY2017 for elements A and F for the SUD providers reviewed.



Another performance improvement effort being implemented is the identification of the need for training for the completion of treatment plans for the SUD providers which will occur during FY2018. This initiative was identified as it was noted during this year's review that not all services were consistently being identified in the individual plan of service.

MSHN also reviews the verification results with the following council and committees:

Note: MSHN council and committee membership consists of representatives from each CMHSP.

- MSHN Regional Consumer Advisory Council
- MSHN Quality Improvement Council

Councils and committees review and provide feedback for region-wide performance improvement opportunities. In addition, discussion and sharing regarding local improvement opportunities provides collaboration efforts to increase compliance.

Future Outlook

MSHN is beginning its third year of reviews and will focus on plans of corrections from previous reviews to ensure indicated quality improvement is taking place. MSHN will work with the CMHSPs and the SUD provider network to collaboratively develop consistent documentation that adheres to best practice standards across the region. MSHN will evaluate the internal MEV policy and procedure on an ongoing basis to ensure compliance with Federal and State standards as well as to ensure consistency and best practices are followed. MSHN will complete a monthly review of outstanding issues related to the MEV review and identify any trends found during the reviews in FY2018.

IV. Performance Improvement Project – HEDIS

Diabetes Screening for Antipsychotics

MSHN PIP Report

Measure Definition

Certain medications used to treat psychiatric disorders may increase the risk of obesity and diabetes and thus CVD, where mortality is greater for this population. [1]

This measure is modeled on the HEDIS measure "Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)" (see details at: NQF 1932), though it does not use the same measurement year timeframe.

The measure looks at the percentage of patients between 18 and 64 years of age with schizophrenia or bipolar disorder, who were dispensed a second-generation antipsychotic (SGA) medication and had a diabetes screening test during the measurement year[2]. The measure excludes patients with diabetes (determined either by diagnostic codes on claims or the presence of prescriptions for diabetic medications) to ensure that we are looking at screening and not ongoing monitoring.

Evaluation

HSAG evaluates the technical structure of the PIP to ensure that Mid-State Health Network designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., study question, indicator(s), population, sampling techniques, data collection methodology, and data analysis plan) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well Mid-State Health Network improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results). The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP.

1American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and North American Association for the Study of Obesity. (2004). Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes care, 27(2). Available at: http://care.diabetesjournals.org/content/27/2/596.full#sec-3

2 I.e. One or more glucose or HbA1c tests.

Study Topic/Indicator/Goal

PIP Topic	Study Indicator	Study Goal
Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications.	*The indicator is the proportion of the eligible population having at least one diabetes screening completed in the measurement year.*	*To ensure that adult consumers with schizophrenia or bipolar disorder who are prescribed antipsychotic medication are receiving the necessary diabetes screenings because taking antipsychotic medications is associated with increased risk of developing diabetes.*

The study topic selected by Mid-State Health Network addressed CMS' requirements related to quality outcomes— specifically, the quality and accessibility of care and services.

Identified Barriers and Interventions

The identification of barriers in achieving the stated goal was completed through causal/barrier analysis. Each CMHSP reviewed their local baseline data and remeasurement period one data and provided feedback regarding the barriers to the PIHP using their local quality improvement process. The PIHP utilized the regional Quality Improvement Council to further identify region wide barriers to receiving a glucose test or an HbA1c test as well as the interventions to overcome the barriers. The process used for the causal/barrier analysis was brainstorming and the completion of a fishbone diagram.

Remeasurement Period One:

The common barriers identified within the region were:

- Behavioral Health services beneficiary not understanding the importance of having a primary care physician and maintaining regular appointments to address health care needs.
- Limited number of primary care physicians accepting Medicaid patients.
- Lack of awareness of benefit coverage for diabetes testing.
- Lack of coordination exists between behavioral health system and primary care physicians.

To assist with overcoming the identified barriers, MSHN implemented the following interventions:

- Provide education to consumers during the person-centered planning process and during face-to-face interactions about the importance of ongoing monitoring by a primary care physician.
- Community Mental Health agencies will coordinate with the consumer and primary care physician regarding the completion of testing.

Remeasurement Period Two:

During this remeasurement period another casual/barrier analysis was completed utilizing the regional Quality Improvement Council. It was determined that the interventions that were implemented during remeasurement period one were successful and therefore should continue into this period.

The following additional common barrier was identified:

- There is a lack of access to lab work completion data

To assist with overcoming the identified barrier, MSHN will implement the following intervention:

- MSHN will utilize the ICDP database to run a care alert report that included data on the Diabetes Screening Key Performance Indicator (KPI) in real time. The care alerts include individuals

who are currently open to the CMHSP and who have not had a diabetes screening completed within the past 12 months.

Remeasurement Period One Goal

Remeasurement period one covered the time period of October 01, 2014 through September 30, 2015. The goal was to show an increase of 1% over the baseline rate of diabetes screenings (Note: Not the same as a 1 percentage-point increase).

Note: The goal for this period was to increase to 75% from the baseline rate of 73.7%. The actual percentage achieved was 77.5%, which was 2.9 percentage points above the baseline rate.

Remeasurement Period Two Goal

Remeasurement period two covered the time period of October 01, 2015 through September 30, 2016. The goal is to show an increase of 1.5 percentage points and a 1 percent increase over remeasurement period one.

Note: The goal for this period was to increase to 79% from the remeasurement period one rate of 77.5%. The actual percentage achieved was 80.4%, which was 3.8 percentage points above the remeasurement period one rate.

Explanation of Scoring

Each required activity is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*.

HSAG looks at the following stages: Design, Implementation and Evaluation and Outcomes.

The Study Design looks at if MSHN designed a scientifically sound study supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design allowed for the successful progression to the next stage of the PIP process.

The Study Implementation and Evaluation looks to see if MSHN progressed to completing causal/barrier analysis using quality improvement tools and implementing interventions likely to impact outcomes. MSHN submitted and analyzed remeasurement period one data in this year's validation. For the next annual validation, study outcomes will be assessed by comparing Mid-State Health Network's remeasurement two results with remeasurement period one.

Results: (Review of 27 elements)

Name of Project/Study	Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications	Initial Submission	100%	100%	Met
	No Resubmission Necessary			

Percentage Score of Evaluation Elements *Met*—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
Percentage Score of Critical Elements *Met*—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
Overall Validation Status—Populated from the PIP Validation Tool and based on the percentage scores.

Conclusion/Summary

The **Mid-State Health Network** PIP received a *Met* score for 100 percent of critical evaluation elements and for 100 percent of the overall evaluation elements in the Study Design and Implementation and Evaluation stages.

The performance of this PIP suggests a thorough application of the PIP design, appropriate analysis of the results (showing statistical significant improvement), and implementation of system interventions related to barriers identified through quality improvement processes.

Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

V. Performance Improvement Project – RAS

Overview of Mid-State Health Network Recovery Assessment Scale Summary Report FY 2017

Consumer Outcome Measure

Introduction

The Recovery Assessment Scale (RAS) was developed as an outcome measure for program evaluations. Based on a process model of recovery, the RAS attempts to assess aspects of recovery with a special focus on hope and self-determination.

The tool is distributed to adult consumers with a diagnosis of mental illness to assess the perceptions of individual recovery. All items are rated using the same 5-point Likert scale that ranges from 1 = "strongly disagree" to 5 = "strongly agree."

The distribution period was January 1, 2017 through March 31, 2017 and this marks the third year of implementation.

The following overview of Mid-State Health Network's (MSHN) Recovery Assessment Scale was developed to assist MSHN Community Mental Health Service Program (CMHSP) participants and other stakeholders develop a better understanding of the strengths and weaknesses in MSHN's recovery-oriented care. This report was developed utilizing voluntary self-reflective surveys from consumers representing all 12 CMHSPs. The survey results were aggregated and scored as outlined in the University of Sydney instructions.

Agency	Total Respondents	Initial Surveys	Ongoing Surveys
Mid-State Health Network	2991	1492	1499
Bay-Arenac Behavioral Health Authority	584	254	330
Community Mental Health Authority of CEI	225	14	211
Community Mental Health for Central Michigan	675	447	228
Gratiot Integrated Health Network	106	56	50
Huron Behavioral Health	90	51	39
LifeWays Community Mental Health	288	144	144
Montcalm Care Network	169	165	4
Newaygo County Community Mental Health	147	81	66
Saginaw County Community Mental Health	370	148	222
Shiawassee County Community Mental Health	184	53	131
The Right Door for Hope Recovery and Wellness	22	10	12
Tuscola Behavioral Health	131	69	62

The information from this report is intended to support discussions on improving recovery-oriented practices by understanding how the various CMHSP practices may facilitate or impede recovery. The

information from this overview should not be used to draw conclusions or make assumptions without further analysis.

Any questions regarding the report should be sent to Kim Zimmerman, MSHN Director of Compliance, Customer Service and Quality, at kim.zimmerman@midstatehealthnetwork.org or Dan Dedloff, MSHN Customer Service and Rights Specialist, at dan.dedloff@midstatehealthnetwork.org.

MSHN Summary

The responses from the Recovery Assessment Scale survey were scored as a comprehensive total and into three (3) separate domains. The comprehensive score measures how the system is performing as a whole, and the performance of three (3) separate domains, and one (1) uncategorized area:

- PERSONAL RECOVERY
  - Questions 1, 3, 4, 5, 7, 8, 9, 10, 11, 15, and 17

    1: I have a desire to succeed
    3: I have goals in life that I want to reach.
    4: I believe I can meet my current personal goals.
    5: I have a purpose in life.
    7: I can handle what happens in my life.
    8: I like myself.
    9: If people really knew me, they would like me.
    10: Something good will eventually happen.
    11: I'm hopeful about my future.
    15: I know when to ask for help.
    17: I ask for help, when I need it.

- CLINICAL RECOVERY
  - Questions 2, 13, and 14

    2: I have my own plan for how to stay or become well.
    13: My symptoms interfere less and less with my life.
    14: My symptoms seem to be a problem for shorter periods of time each time they occur.

- SOCIAL RECOVERY
  - Questions 6, 18, 19, and 20

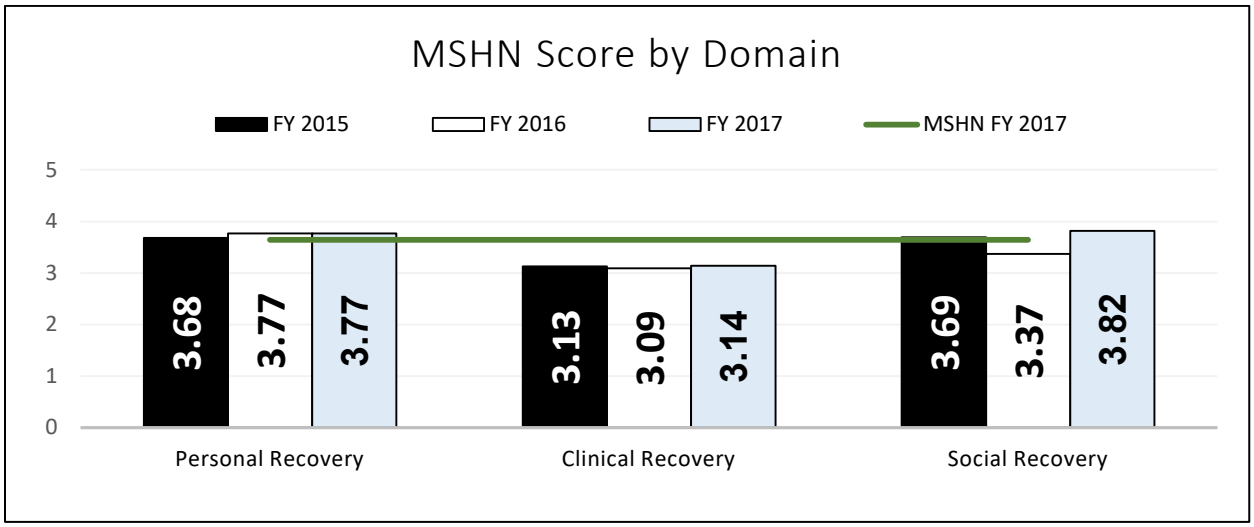
    6: Even when I don't care about myself, other people do.
    18: I have people I can count on.
    19: Even when I don't believe in myself, other people do.
    20: It is important to have a variety of friends.

- UNCATEGORIZED QUESTIONS
  - Questions 12 and 16

    12: Coping with my mental illness is no longer the main focus of my life.
    16: I am willing to ask for help.

Figure 1 illustrates how MSHN's 12 CMHSPs scored themselves comprehensively and in the three (3) separate domains. The MSHN comprehensive score for FY 2015 was 3.57, FY 2016 was 3.63, and FY 2017 was 3.64.

Fig. 1 – MSHN Score by Domain

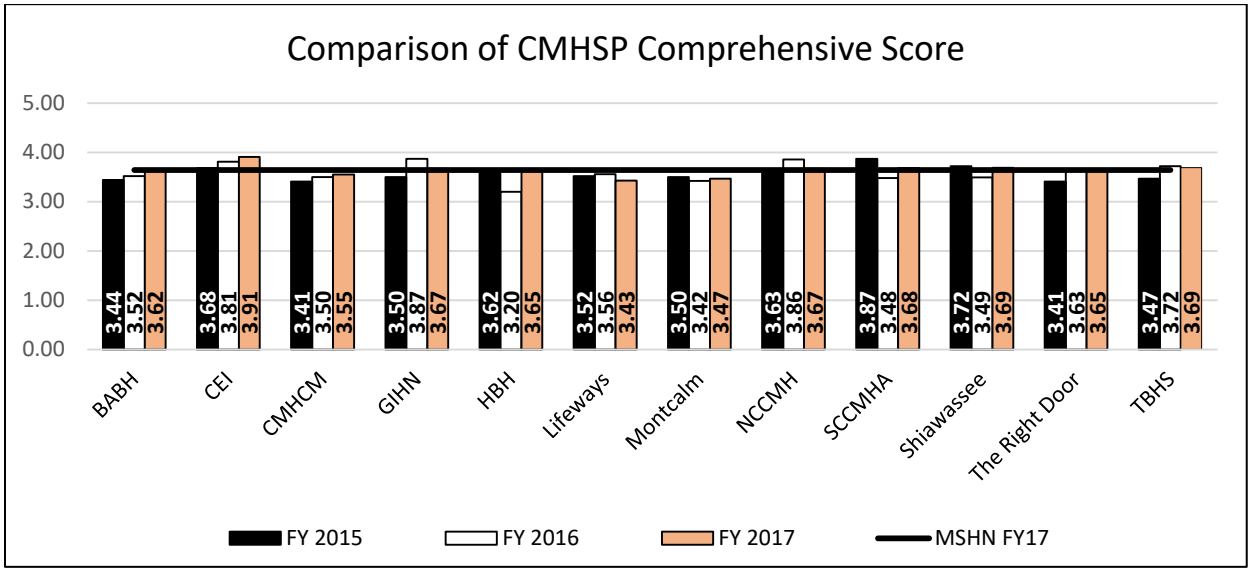


MSHN CMHSP Summary

The responses from the Recovery Assessment Scale survey were also analyzed by CMHSP, scored comprehensively, and by the separate domains.

Figure 2 illustrates how each CMHSP scored comprehensively in FY 2015, FY 2016, and FY 2017. The MSHN comprehensive score for FY 2015 was 3.57, FY 2016 was 3.63, and FY 2017 was 3.64

Fig. 2 – Comparison of CMHSP Comprehensive Score



PLEASE NOTE: For each of the following graphs, the data is compared between FY 2016 and FY 2017. During FY 2015 the surveys that were completed were not separated into "initial" and "ongoing. Therefore, there is no differentiated comparison data available for FY 2015.

Figure 3 illustrates how each CMHSP scored comprehensively with the Initial Recovery Assessment Scale survey responses for FY 2016 compared to FY 2017. The MSHN comprehensive scores for the Initial surveys was 3.48 for FY 2016, and 3.54 for FY 2017.

Fig. 3 – Comparison of CMHSP Comprehensive Score of Initial survey responses.

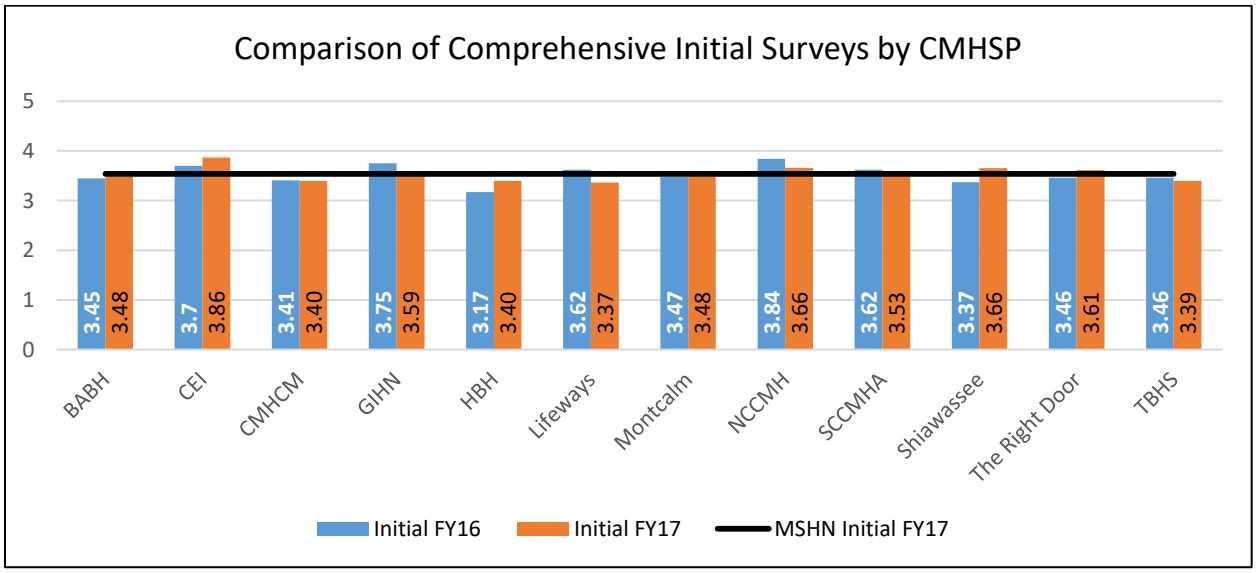


Figure 4 illustrates how each CMHSP scored comprehensively with the Ongoing Recovery Assessment Scale survey responses for FY 2016 compared to FY 2017. The MSHN comprehensive scores for the Ongoing surveys was 3.76 for FY 2016, and 3.75 for FY 2017.

Fig. 4 – Comparison of CMHSP Comprehensive Score of Ongoing survey responses.

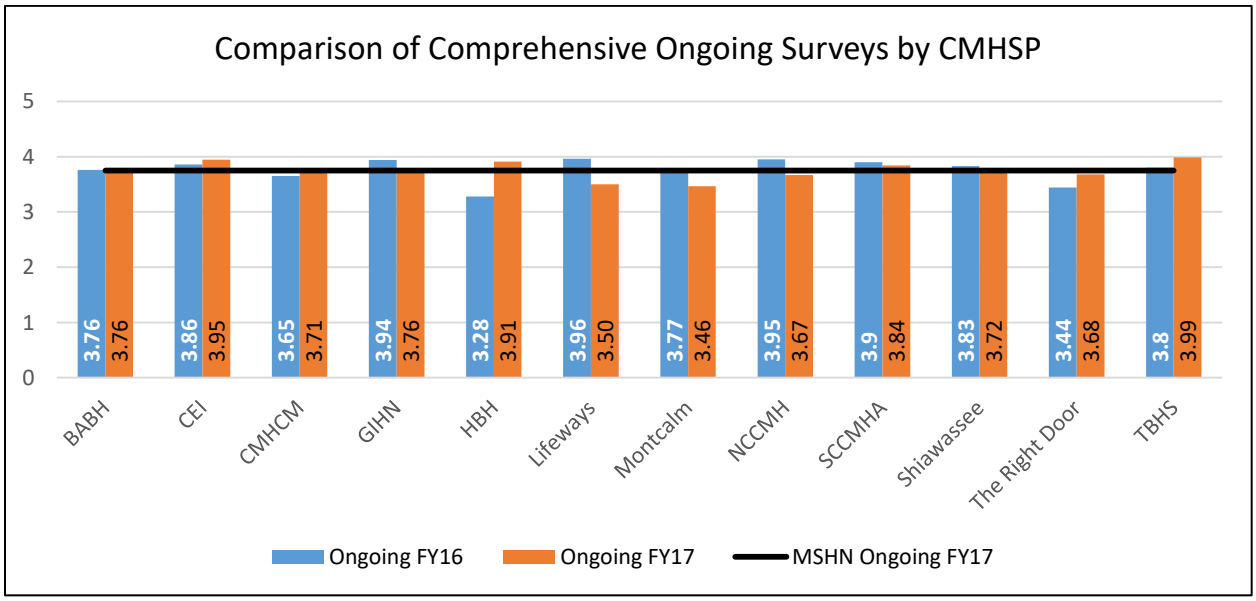


Figure 5 illustrates how each CMHSP scored in the Personal Recovery domain for Initial surveys in FY 2016 and FY 2017. The MSHN score for the Personal Recovery domain for Initial surveys was 3.31 in FY 2016, and 3.67 in FY 2017.

Fig. 5 – Comparison of CMHSP Initial Personal Recovery Scores.

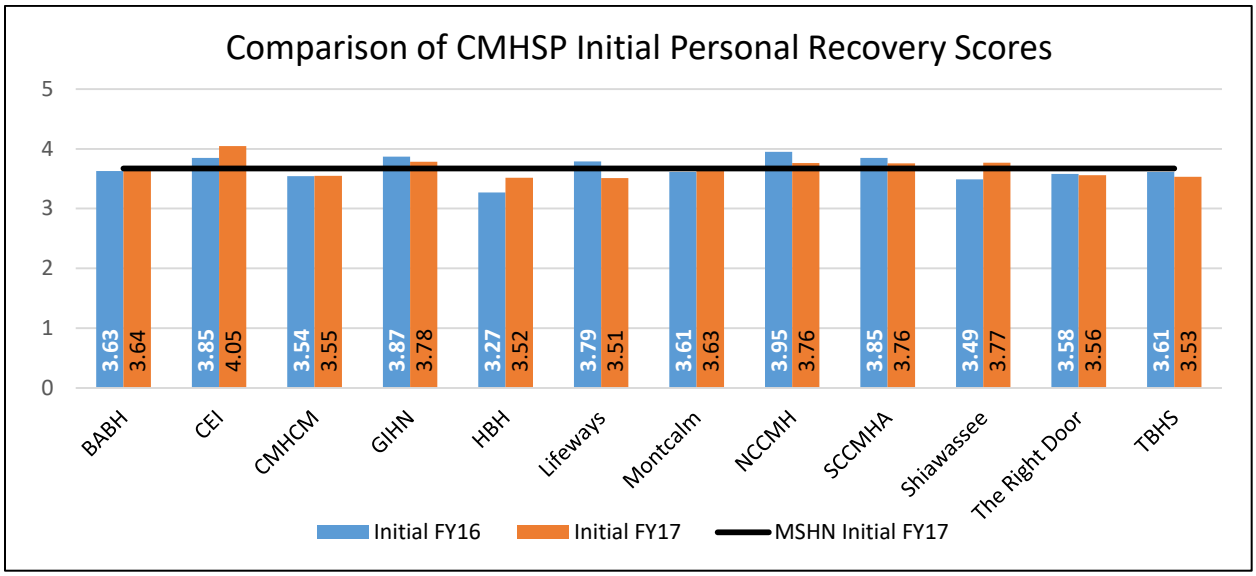


Figure 6 illustrates how each CMHSP scored in the Personal Recovery domain for Ongoing surveys in FY 2016 and FY 2017. The MSHN score for the Personal Recovery domain for Ongoing surveys was 3.87 in FY 2016, and 3.86 in FY 2017.

Fig. 6 - Comparison of CMHSP Ongoing Personal Recovery Scores.

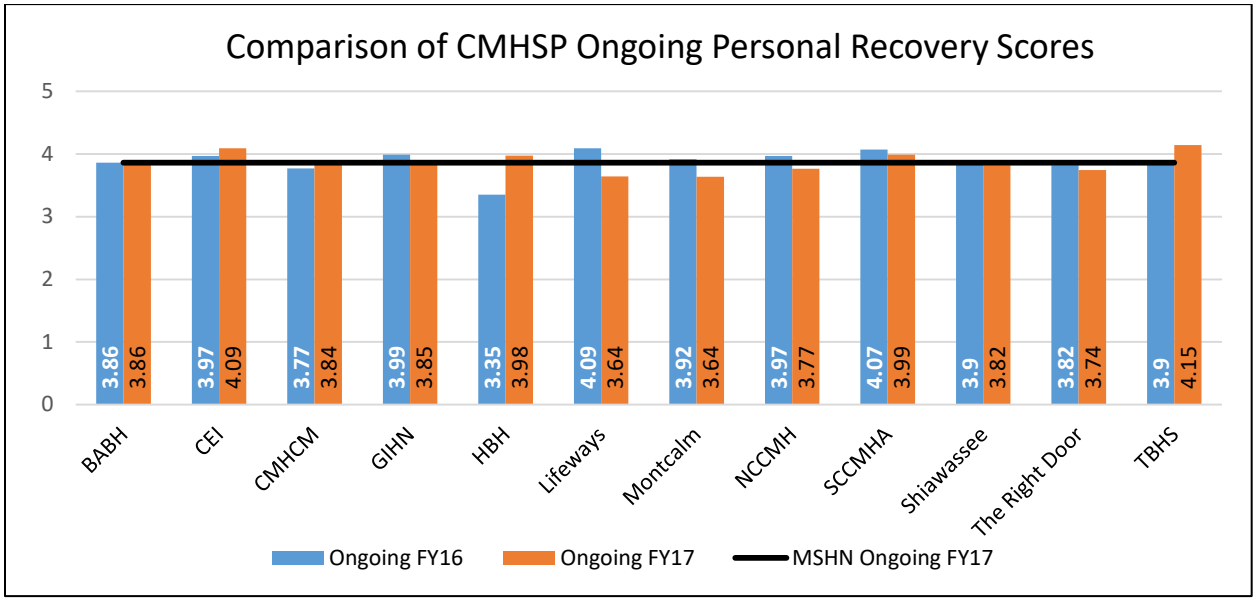


Figure 7 illustrates how each CMHSP scored in the Clinical Recovery domain for Initial surveys in FY 2016 and FY 2017. The MSHN score for the Clinical Recovery domain for Initial surveys was 2.82 for FY 2016, and 2.93 for FY 2017.

Fig 7 – Comparison of CMHSP Initial Clinical Recovery Scores.

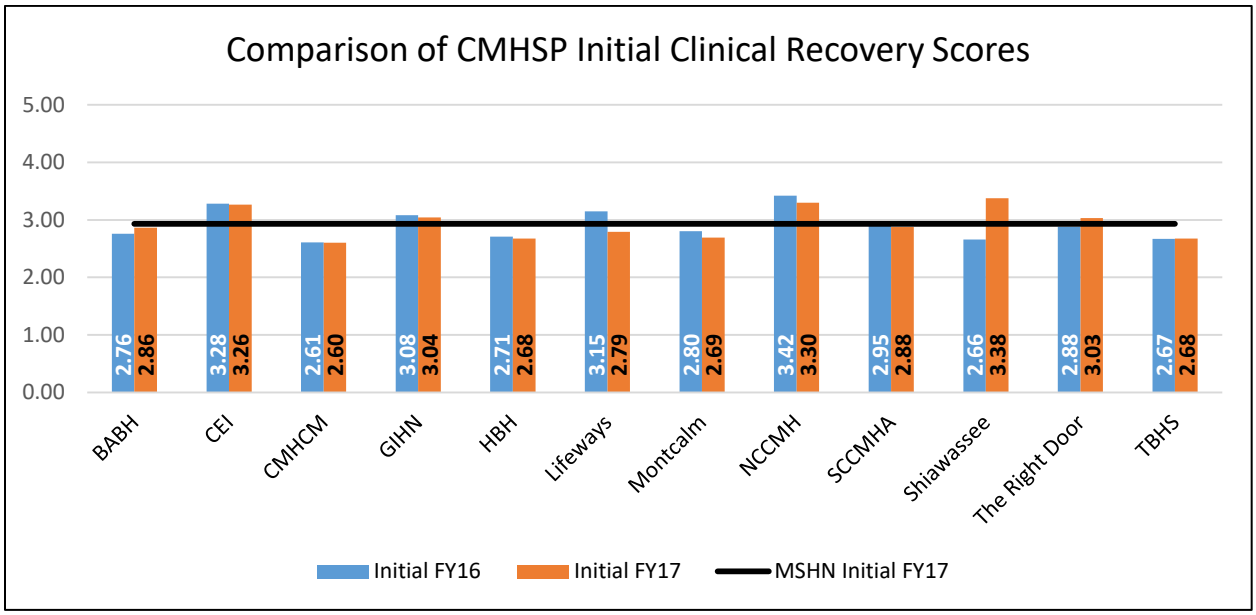


Figure 8 illustrates how each CMHSP scored in the Clinical Recovery domain for Ongoing surveys in FY 2016 and FY 2017. The MSHN score for the Clinical Recovery domain for Ongoing surveys was 3.37 for FY 2016, and 3.34 for FY 2017.

Fig 8 – Comparison of CMHSP Ongoing Clinical Recovery Scores.

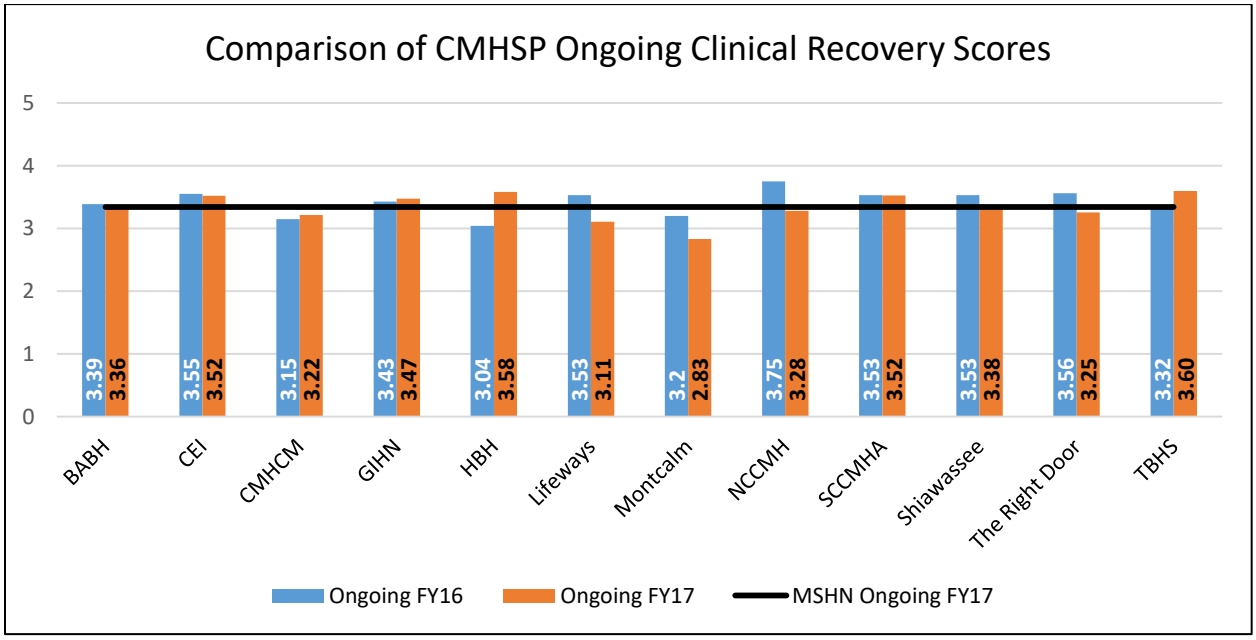


Figure 9 illustrates how each CMHSP scored in the Social Recovery domain for Initial surveys in FY 2016 and FY 2017. The MSHN score for the Social Recovery domain for Initial surveys was 3.69 for FY 2016, and 3.75 for FY 2017.

Fig 9 – Comparison of CMHSP Initial Social Recovery Scores.

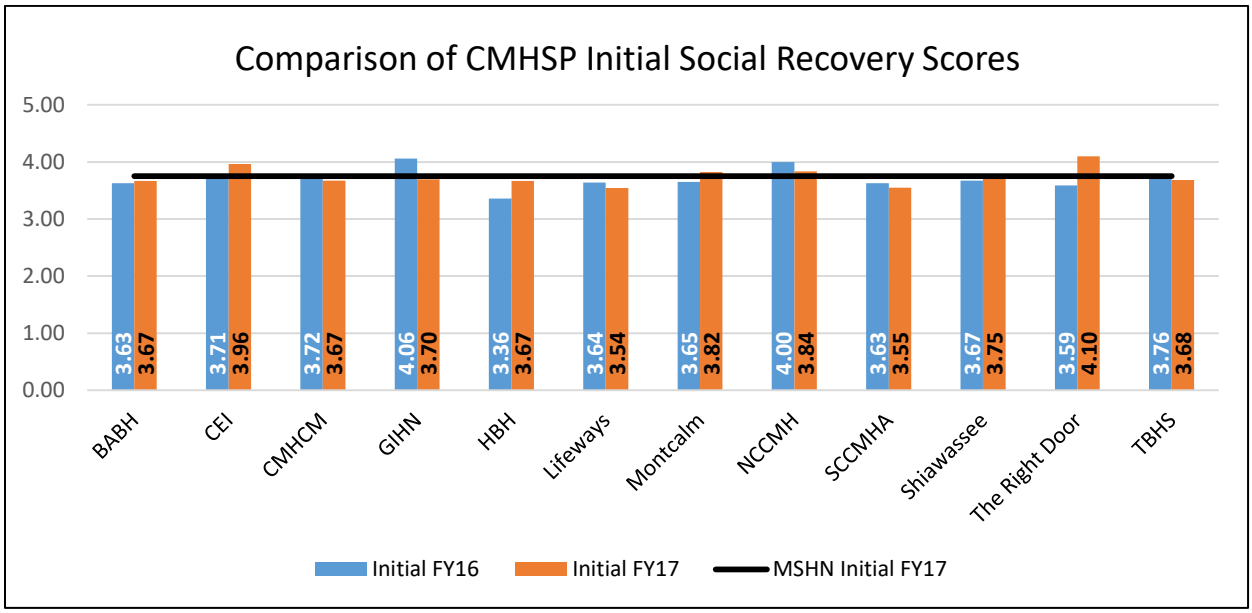
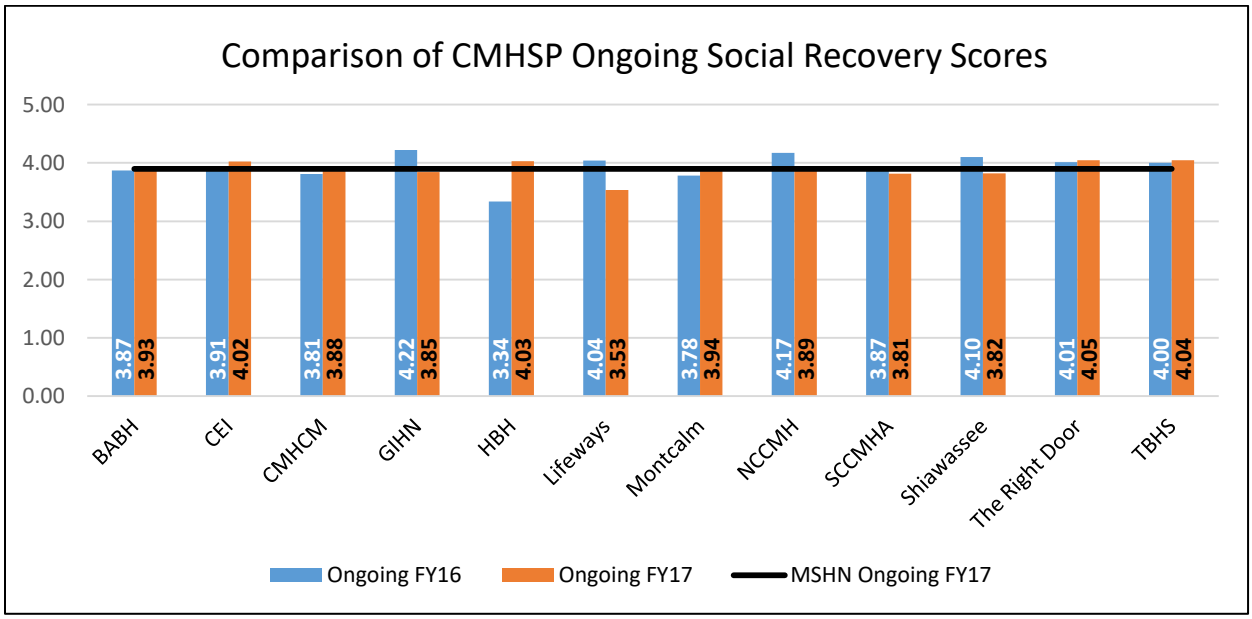


Figure 10 illustrates how each CMHSP scored in the Social Recovery domain for Ongoing surveys in FY 2016 and FY 2017. The MSHN score for the Social Recovery domain for Ongoing surveys was 3.88 for FY 2016, and 3.90 for FY 2017.

Fig 10 – Comparison of CMHSP Ongoing Social Recovery Scores.



MSHN Recovery Assessment Scale Domain Response

The responses from the Recovery Assessment Scale survey were analyzed by domain questions and responses for MSHN. The percentage of responses the from 5-point Likert scale that ranges from 1 = "strongly disagree" to 5 = "strongly agree" were calculated for each question within each domain.

Figures 11 and 12 illustrate how MSHN's 12 CMHSPs responded to the eleven (11) Personal Recovery Domain question. (Figure 11: Initial Surveys, and Figure 12: Ongoing Surveys). The questions included in this domain are as follows:

1: I have a desire to succeed
3: I have goals in life that I want to reach.
4: I believe I can meet my current personal goals.
5: I have a purpose in life.
7: I can handle what happens in my life.
8: I like myself.
9: If people really knew me, they would like me.
10: Something good will eventually happen.
11: I'm hopeful about my future.
15: I know when to ask for help.
17: I ask for help, when I need it.

Fig. 11 – MSHN – Initial Survey: Personal Recovery Domain Response.

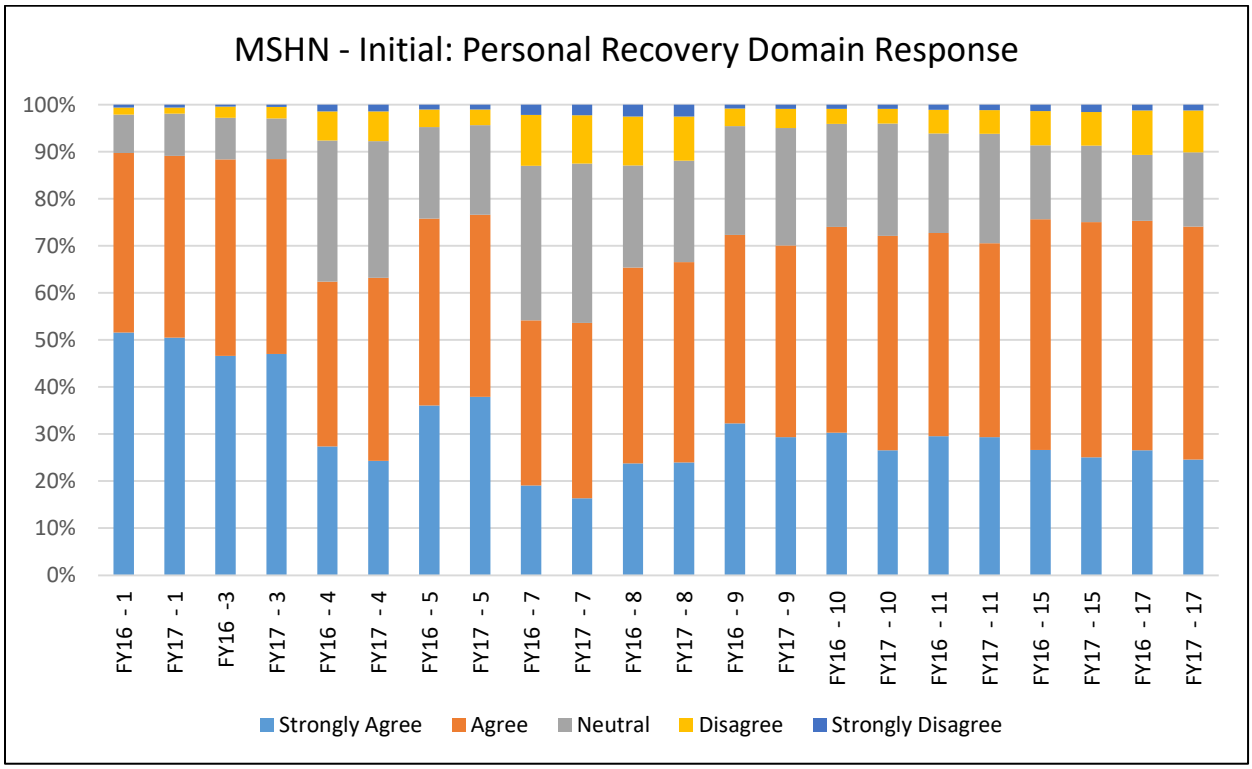
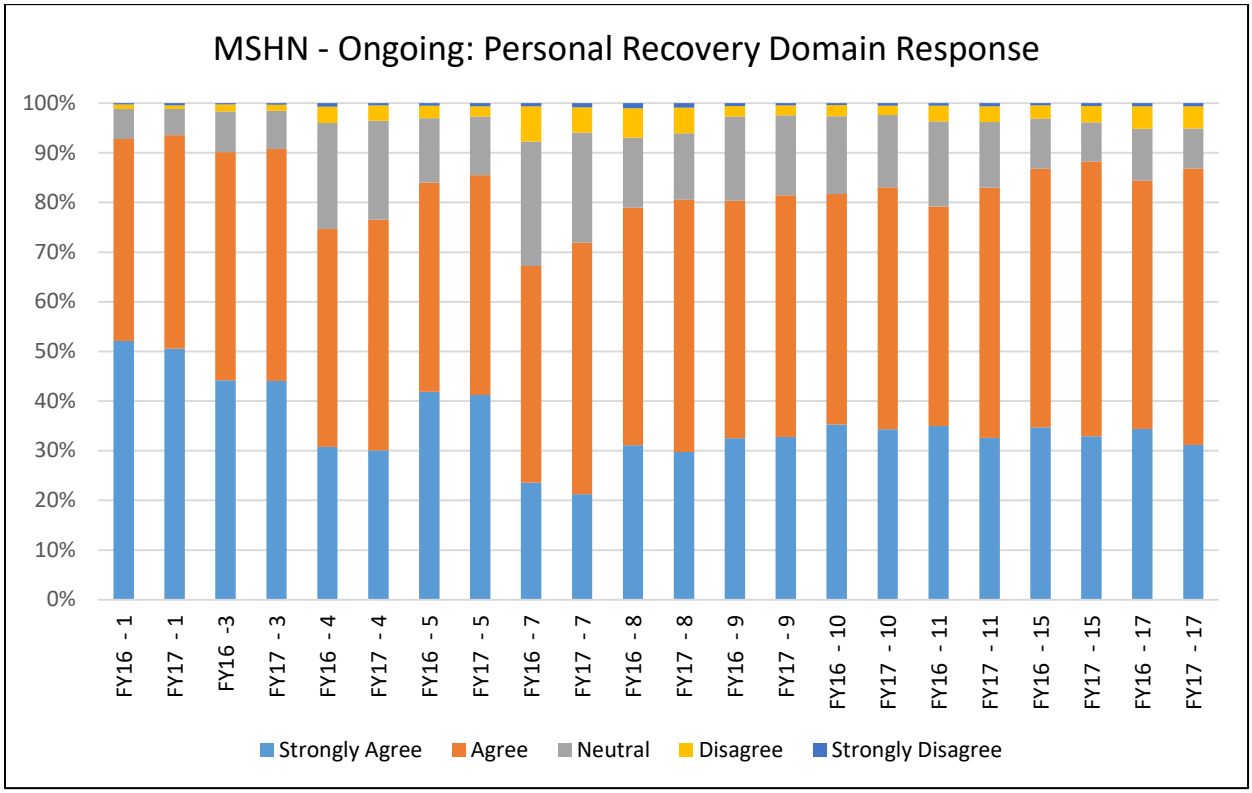


Fig. 12 – MSHN – Ongoing Survey: Personal Recovery Domain Response.



Figures 13 and 14 illustrate how MSHN's 12 CMHSPs responded to the three (3) Clinical Recovery Domain questions. (Figure 13: Initial Surveys, and Figure 14: Ongoing Surveys). The questions included in this domain are as follows:

2: I have my own plan for how to stay or become well.
13: My symptoms interfere less and less with my life.
14: My symptoms seem to be a problem for shorter periods of time each time they occur.

Fig. 13 – MSHN – Initial Survey: Clinical Recovery Domain Response.

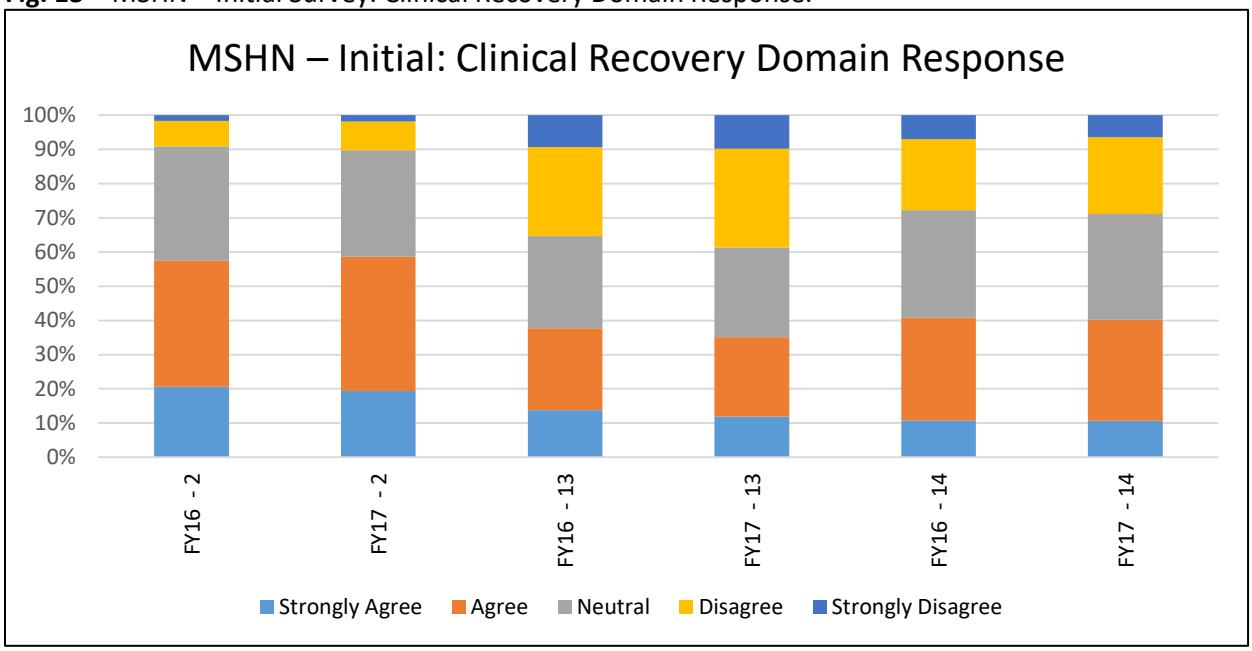
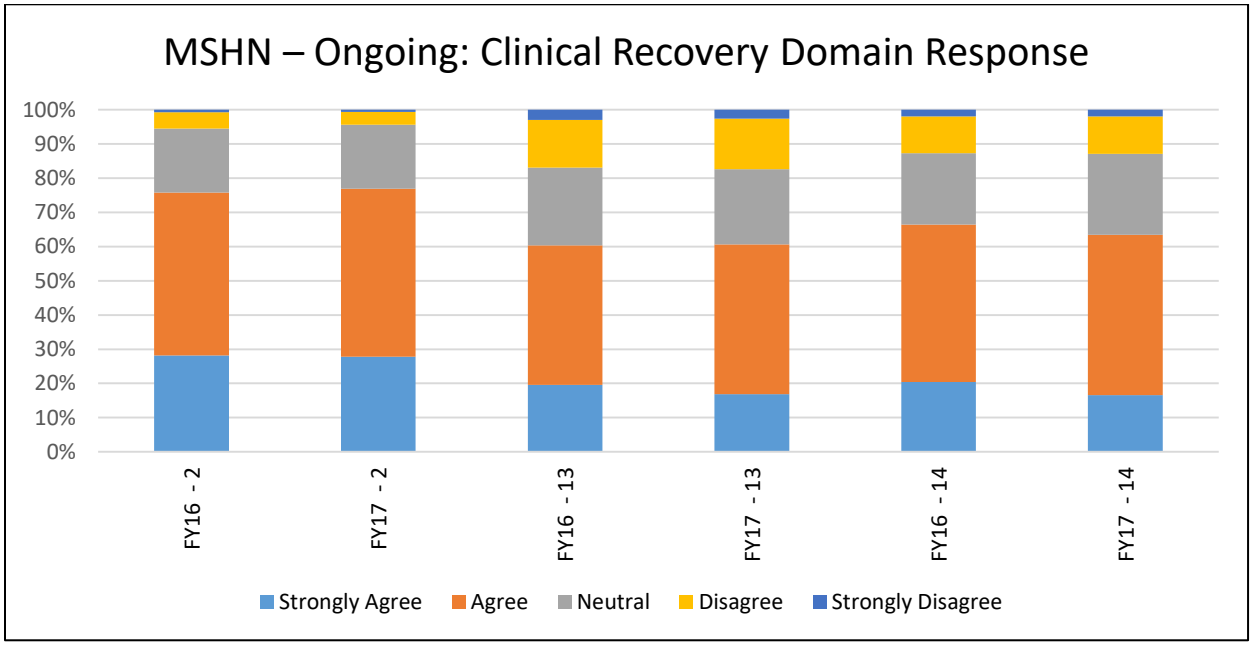


Fig. 14 – MSHN – Ongoing Survey: Clinical Recovery Domain Response.



Figures 15 and 16 illustrate how MSHN's 12 CMHSPs responded to the four (4) Social Recovery Domain questions. (Figure 15: Initial Surveys, and Figure 16: Ongoing Surveys). The questions included in this domain are as follows:

6: Even when I don't care about myself, other people do.
18: I have people I can count on.
19: Even when I don't believe in myself, other people do.
20: It is important to have a variety of friends.

Fig. 15 – MSHN – Initial Survey: Social Recovery Domain Response.

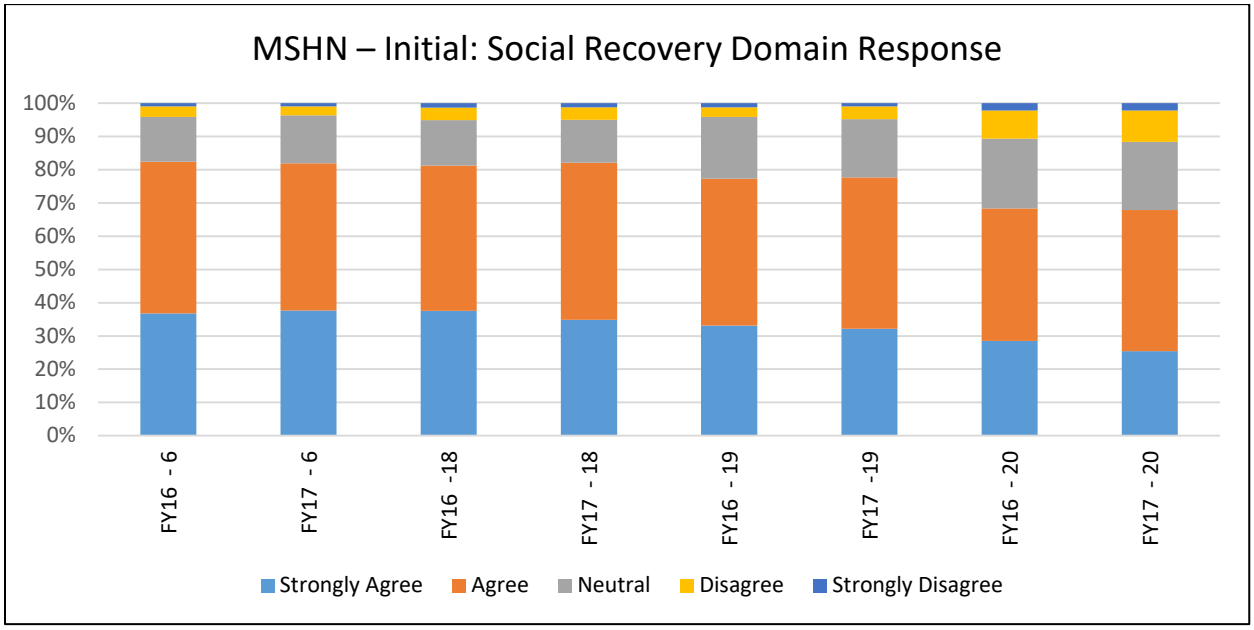
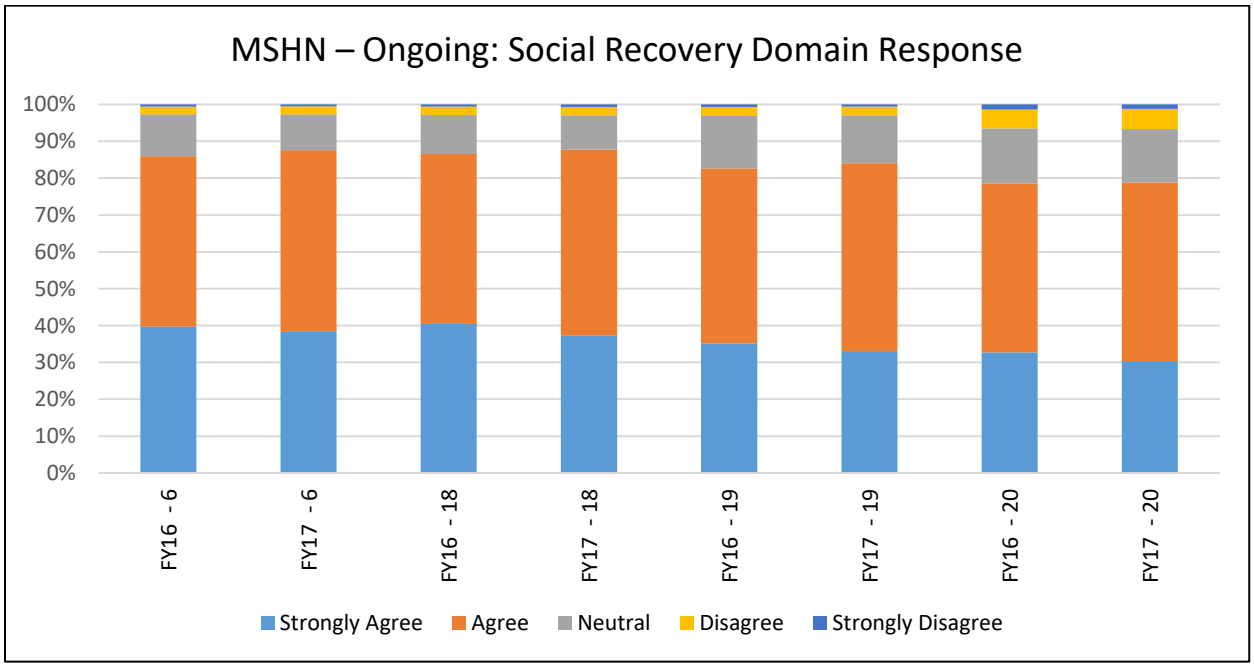


Fig. 16 – MSHN – Ongoing Survey: Social Recovery Domain Response.



Figures 17 and 18 illustrate how all 12 CMHSPs responded to two (2) uncategorized questions. (Figure 17: Initial Surveys, and Figure 18: Ongoing Surveys). The questions included are as follows:

12: Coping with my mental illness is no longer the main focus of my life.
16: I am willing to ask for help.

Fig. 17 – MSHN – Initial Survey: Uncategorized Response.

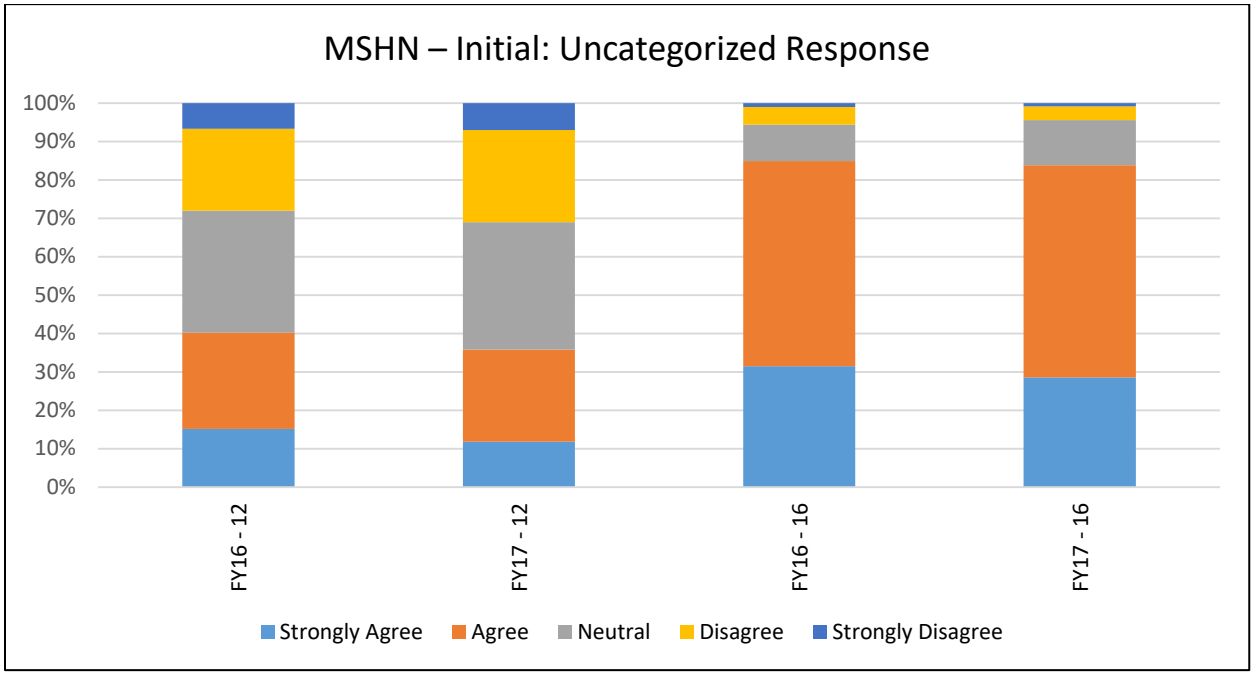
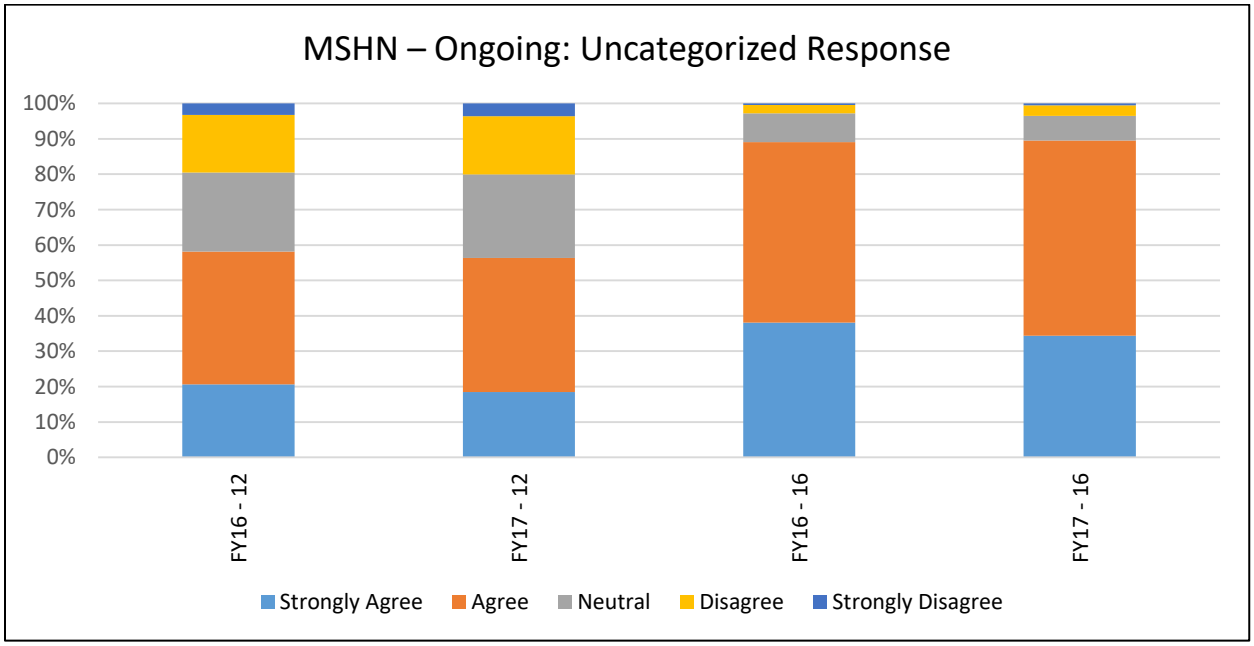


Fig. 18 – MSHN – Ongoing Survey: Uncategorized Response.



Conclusion:

The results in Figure 1 and 2 compare the FY 2017 results to the prior FY 2016 and FY 2015 results.

Figure 1:

The MSHN comprehensive score for FY 2015 was 3.57, FY 2016 was 3.63, and FY 2017 was 3.64. The results per domain identified a stable result for the personal recovery domain and an increase in the clinical and social recovery domains when compared to the results from FY2016.

Figure 2:

The MSHN comprehensive score for FY 2015 was 3.57, FY 2016 was 3.63, and FY 2017 was 3.64. The FY 2017 scores identified that eight (8) CMHSPs showed an improvement when compared to FY 2016 results and four (4) showed a decrease.

Figures 3 through 18 contain results for the FY 2017 and FY 2016 surveys.

Figure 3:

The FY 2017 CMHSP comprehensive scores compared the Initial Recovery Assessment Scale survey responses for FY 2016 to FY 2017. The MSHN comprehensive scores for the Initial surveys was 3.48 for FY 2016, and 3.54 for FY 2017. Six (6) CMHSP's showed an improvement when compared to FY 2016 and 6 (six) showed a decrease.

Figure 4:

The FY 2017 CMHSP comprehensive score compared the Ongoing Recovery Assessment Scale survey responses for FY 2016 to FY 2017. The MSHN comprehensive scores for the Ongoing surveys was 3.76 for FY 2016, and 3.75 for FY 2017. Five (5) CMHSPs showed an improvement, one (1) was equal, and six (6) showed a decrease when compared to FY2016.

Figure 5:

The FY 2017 CMHSP score for the Personal Recovery domain for Initial surveys compared the FY 2016 and FY 2017 results. The MSHN score for the Personal Recovery domain for Initial surveys was 3.31 in FY 2016, and 3.67 in FY 2017. Six (6) CMHSPs showed an improvement when compared to FY2016 and 6 (six) showed a decrease.

Figure 6:

The FY 2017 CMHSP score for the Personal Recovery domain for Ongoing surveys compared the FY 2016 and FY 2017 results. The MSHN score for the Personal Recovery domain for Ongoing surveys was 3.87 in FY 2016, and 3.86 in FY 2017. Four (4) CMHSPs showed an improvement, one (1) was equal, and seven (7) showed a decrease when compared to FY 2016.

Figure 7:

The FY 2017 CMHSP score for the Clinical Recovery domain for Initial surveys compared FY 2016 and FY 2017 results. The MSHN score for the Clinical Recovery domain for Initial surveys was 2.82 for FY 2016, and 2.93 for FY 2017. Four (4) CMHSPs showed an improvement and eight (8) showed a decrease when compared to FY 2016.

Figure 8:

The FY 2017 CMHSP score for the Clinical Recovery domain for Ongoing surveys compared the FY 2016 and FY 2017 results. The MSHN score for the Clinical Recovery domain for Ongoing surveys was 3.37 for FY 2016, and 3.34 for FY 2017. Four (4) CMHSPs showed an improvement and eight (8) showed a decrease when compared to FY 2016.

Figure 9:
The FY 2017 CMHSP score for the Social Recovery domain for Initial surveys compared the FY 2016 and FY 2017 results. The MSHN score for the Social Recovery domain for Initial surveys was 3.69 for FY 2016, and 3.75 for FY 2017. Six (6) CMHSPs showed an improvement and six (6) showed a decrease when compared to FY 2016.

Figure 10:

The FY 2017 CMHSP score for the Social Recovery domain for Ongoing surveys compared the FY 2016 and FY 2017 results. The MSHN score for the Social Recovery domain for Ongoing surveys was 3.88 for FY 2016, and 3.90 for FY 2017. Seven (7) CMHSPs showed an improvement and five (5) showed a decrease when compared to FY 2016.

Figure 11 & 12:

The FY 2017 MSHN scores for the Initial and Ongoing Personal Recovery Domain Survey questions showed that most individuals responded with "strongly agreed" or "agreed". Question 1, "I have a desire to succeed", and Question 3, "I have goals in life that I want to reach", were answered with the highest combined scores of "strongly agree" and "agreed". Question 7, "I can handle what happens in my life", was answered with the highest combined scores of "strongly disagree" and "disagree". Scores between FY 2016 and FY 2017 for the Initial and Ongoing Personal Recovery Domain Survey questions were relatively stable between the survey years.

Figure 13 & 14:

The FY 2017 MSHN scores for the Initial and Ongoing Clinical Recovery Domain Survey question "I have my own plan for how to stay or become well" scored the highest for "strongly agreed" and "agreed" for both the "initial" and the "ongoing" group. The question "My symptoms interfere less and less with my life" received the highest combined scores of "strongly disagreed" and 'disagreed" for both the "initial" and "ongoing" group. The percentages for those in the "ongoing" group scored higher in all domain questions versus those in the "initial" survey group. FY 2016 and FY 2017 scores for the Initial and Ongoing Personal Clinical Recovery Domain Survey questions were relatively stable between the survey years.

Figure 15 & 16:

The FY 2017 MSHN scores for the Initial and Ongoing Social Recovery Domain Survey question "I have people I can count on" scored the highest for "strongly agreed" and "agreed" for the both the "initial and "ongoing" groups. The question "It is important to have a variety of friends" received the highest combined scores of "strongly disagreed" and 'disagreed" for both the "initial" and "ongoing" groups. The percentages for those in the "ongoing" group scored higher in all domain questions versus those in

the “initial” survey groups. FY 2016 and FY 2017 scores for the Initial and Ongoing Social Recovery Domain Survey questions were relatively stable between the survey years.
Figure 17 & 18:

The figures showed the results for the two “uncategorized” questions compared between FY 2016 and FY 2017. The question “I am willing to ask for help” had the highest combined responses for “strongly agreed” and “agreed” for both the “initial” and “ongoing” groups. The question “Coping with my mental illness is no longer the main focus of my life” received the highest combined score of “strongly disagreed” and “disagreed” for both the “initial” and “ongoing” groups. Both questions showed a higher percentage among the “ongoing” group versus the “initial” group across years. FY 2016 and FY 2017 scores for the “uncategorized” questions were relatively stable between the survey years.

Summary:

Overall the survey results identified a higher percentage of satisfaction for those in the “ongoing” group versus those in the “initial” group. This is a positive trend that provides evidence that MSHN and the CMHSPs embrace a culture that provides services and supports which are founded in recovery.
The results will be reviewed further by the MSHN Quality Improvement Council to determine if there are any trends between FY 2015, FY 2016, and FY 2017 and if any regional improvement efforts should be made to impact the survey results. Areas of improvement will be targeted toward below average scores (based on the regional average of all scores) in each of the domains and priority areas will be identified through review by the Regional Consumer Advisory Council. Each CMHSP will also review their local results and identify any needs for local improvement efforts.

Report Completed by: Mid-State Health Network Date: 06/2017

MSHN QIC Approved: July 27, 2017

VI. Performance Improvement Project – RSA

Overview of Mid-State Health Network Recovery Self-Assessment Survey Summary Report FY 2017

Provider Network Administrator Measure

Introduction

The following overview of Mid-State Health Network's (MSHN) Recovery Self-Assessment (RSA) Survey was developed to assist MSHN Community Mental Health Service Program (CMHSP) Participants and other stakeholders develop a better understanding of the strengths and weaknesses in MSHN's recovery-oriented care. This report was developed utilizing voluntary self-reflective surveys completed by supervisors representing all CMHSP programs that provide services to adults with a Mental Illness diagnosis. There was a total of 95 respondents representing all 12 CMHSPs. The survey results were aggregated and scored as outlined in the Yale Program for Recovery and Community Health instructions. The tool is intended to assess the perceptions of individual recovery and all items are rated using the same 5-point Likert scale that ranges from 1 = "strongly disagree" to 5 = "strongly agree."

Agency	Respondents
Mid-State Health Network total	95
Bay-Arenac Behavioral Health Authority	9
Community Mental Health Authority of CEI	18
Community Mental Health for Central Michigan	6
Gratiot Integrated Health Network	8
Huron Behavioral Health	3
LifeWays Community Mental Health	7
Montcalm Care Center	7
Newaygo County Community Mental Health	2
Saginaw County Community Mental Health	19
Shiawassee County Community Mental Health	5
The Right Door for Hope Recovery and Wellness	8
Tuscola Behavioral Health System	3

The distribution period was January 15, 2017 through February 15, 2017 and this marks the third year of implementation.

The information from this report is intended to support discussions on improving recovery-oriented practices by understanding how the various CMHSP practices may facilitate or impede recovery. The information from this overview should not be used draw conclusions or make assumptions without further analysis.

Any questions regarding the report should be sent to Kim Zimmerman, Director of Compliance, Customer Service and Quality at kim.zimmerman@midstatehealthnetwork.org or Dan Dedloff, MSHN Customer Service and Rights Specialist at dan.dedloff@midstatehealthnetwork.org.

MSHN Summary

The responses from the Recovery Self-Assessment surveys were scored as a comprehensive total and separately as six subcategories. The comprehensive score measures how the system is performing as a whole, and the subcategories measures the performance of six separate parts:

- INVITE – How welcoming the facility and its staff are to the client
    - Questions included

        1: Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in programs.
        2: This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).

- CHOICE – How the provider takes into account the client's preferences and choices during the recovery process
    - Questions included

        4: Program participants can change their clinician or case manager if they wish.
        5: Program participants can easily access their treatment records if they wish.
        6: Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.
        10: Staff listen to and respect the decisions that program participants make about their treatment and care.

- INVOLVEMENT – How the provider allows clients to become involved in the recovery process
    - Questions included

        22: Staff actively help people find ways to give back to their community (i.e., volunteering, community services, and neighborhood watch/cleanup).
        23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.
        24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.
        25. People in recovery are encouraged to attend agency advisory boards and management meetings.
        29. Persons in recovery are involved with facilitating staff trainings and education at this program.
        33. This agency provides formal opportunities for people in recovery, family members, service providers, and administrators to learn about recovery.
        34. This agency provides structured educational activities to the community about mental illness and addictions.

- LIFE GOALS – How the provider encourages clients to pursue individual goals and interests
    - Questions included

3. Staff encourage program participants to have hope and high expectations for their recovery.
7. Staff believe in the ability of program participants to recover.
8. Staff believe that program participants have the ability to manage their own symptoms.
9. Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.
12. Staff encourage program participants to take risks and try new things.
16. Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).
17. Staff routinely assist program participants with getting jobs.
18. Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.
28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.
31. Staff are knowledgeable about special interest groups and activities in the community.
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.

- INDIVIDUALLY TAILORED SERVICES – How the provider helps clients tailor their treatment programs to their individual needs
    - Questions Included

11. Staff regularly ask program participants about their interests and the things they would like to do in the community.
13. This program offers specific services that fit each participant's unique culture and life experiences.
19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friend, clergy, or an employer).
30. Staff at this program regularly attend trainings on cultural competency.

- DIVERSITY OF TREATMENT – How the provider offers a range of treatment options and style to cater to the client's needs and preferences

    - Questions Included

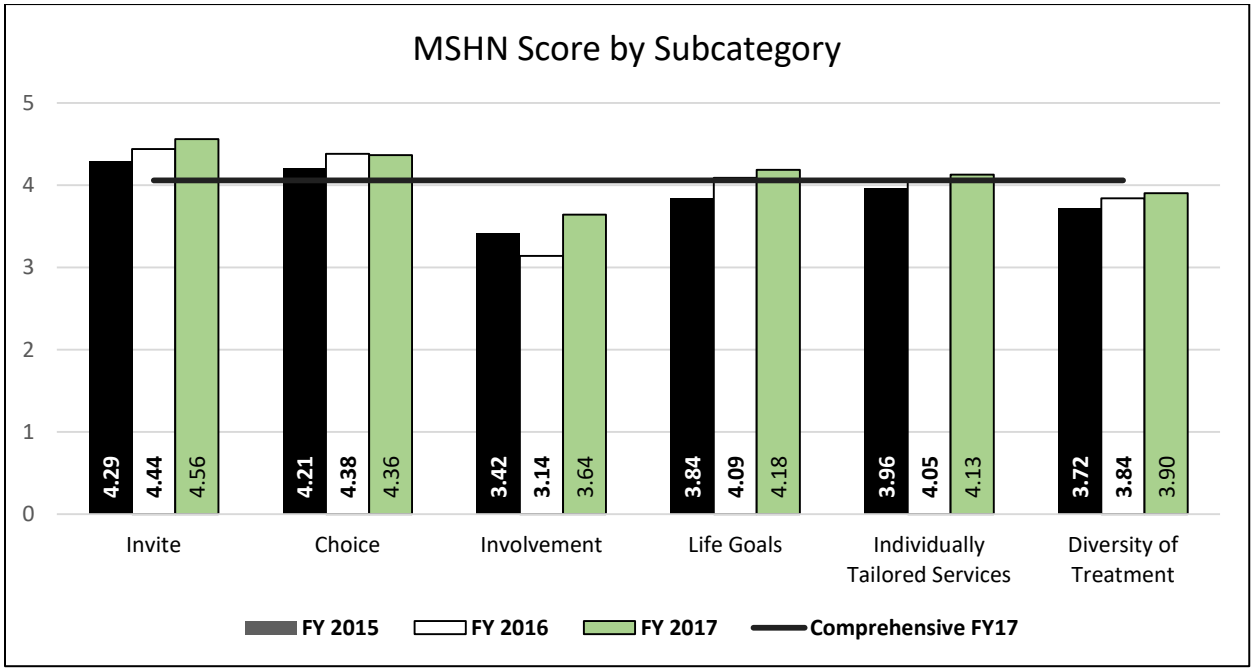
14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.
15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.
20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.
21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.
26. Staff talk with program participants about what it takes to complete or exit the

program.

35. This agency provides a variety of treatment options for program participants (e.g., individual, group, peer support, medical, community-based, employment, skill building, employment, etc.)
36. Groups, meetings, and other activities are scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.

Figure 1 illustrates how MSHN's twelve CMHSPs scored themselves comprehensively and in the six separate subcategories. The comprehensive score for FY 2015 was 3.82, 4.00 for FY 2016, and 4.06 for FY 2017.

Fig. 1 – MSHN Score by Subcategory



MSHN CMHSP Summary

The responses from the Recovery Self-Assessment scores were also separated by each CMHSP comprehensively, and by each of the subcategory scores.

Figure 2 illustrates how each CMHSP scored comprehensively. The MSHN average was 3.82 for FY 2015, 4.00 for FY 2016, and 4.06 for FY 2017.

Fig. 2 – Comparison of CMHSP Comprehensive Score

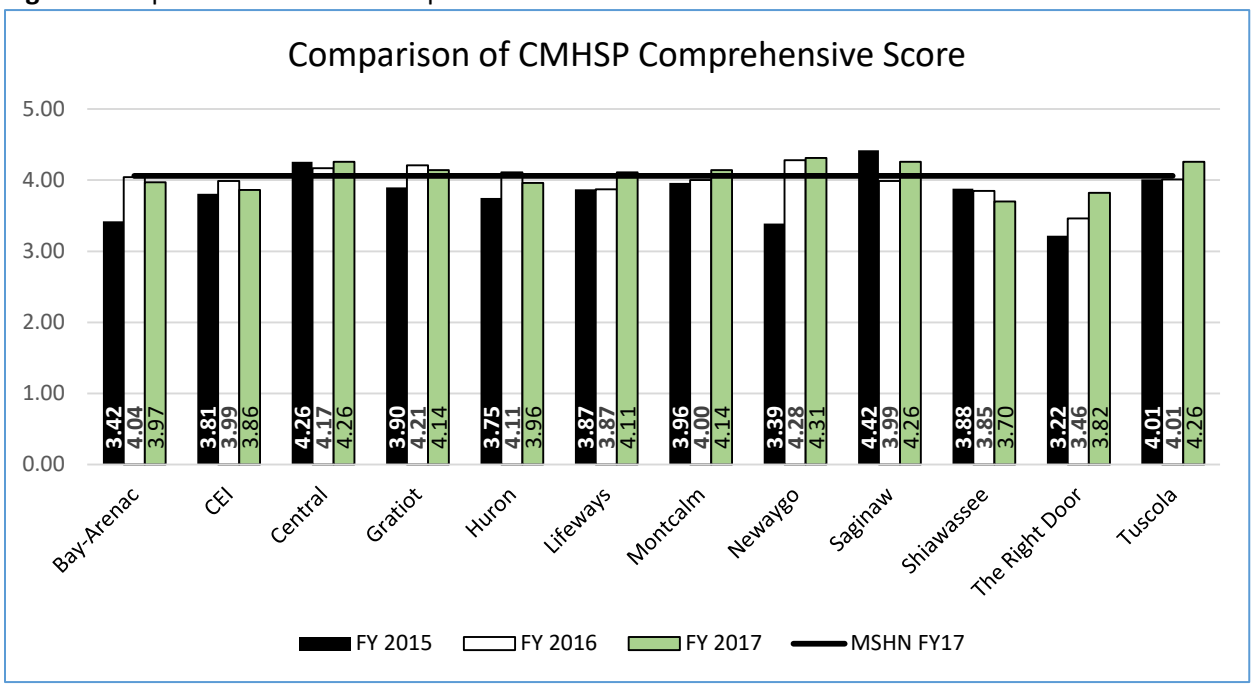


Figure 3 illustrate how each CMHSP scored in the Invite subcategory. The MSHN average was 4.29 for FY 2015, 4.44 for FY 2016, and 4.56 for FY 2017.

Fig. 3 – Comparison of CMHSP Invite Subcategory Score

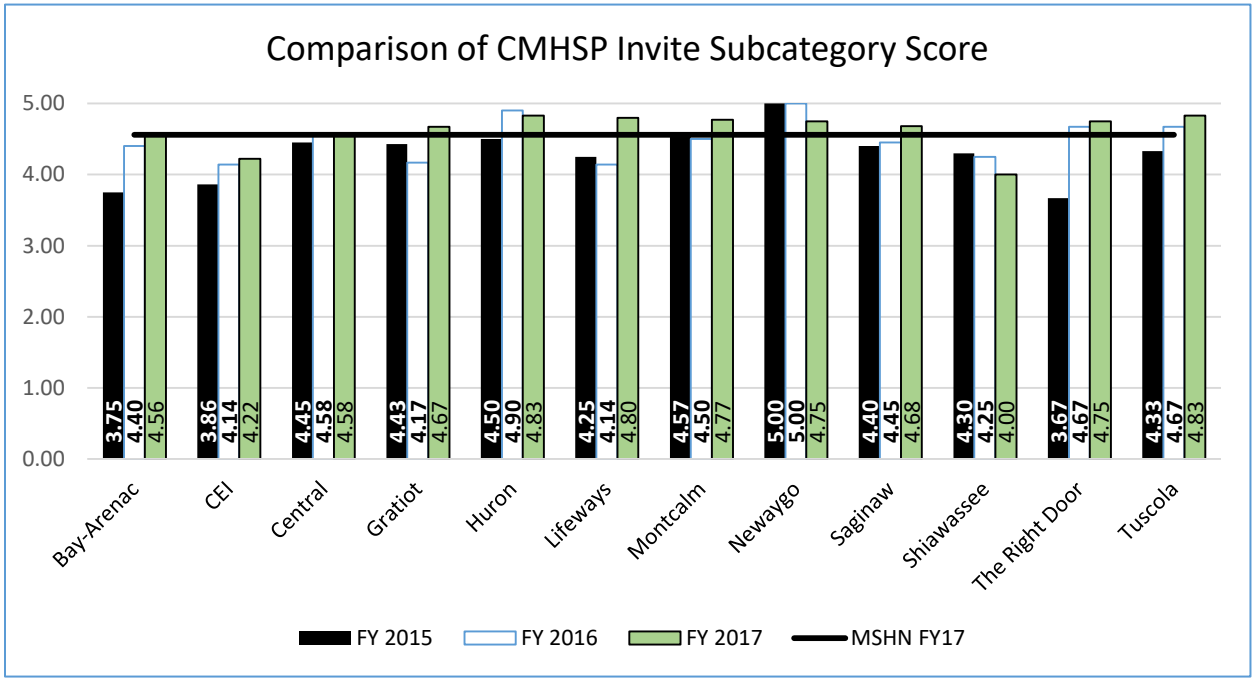


Figure 4 illustrates how each CMHSP scored in the Choice subcategory. The MSHN average for FY 2015 was 4.21, 4.38 for FY 2016, and 4.36 for FY 2017.

Fig. 4. – Comparison of CMHSP Choice Subcategory Score

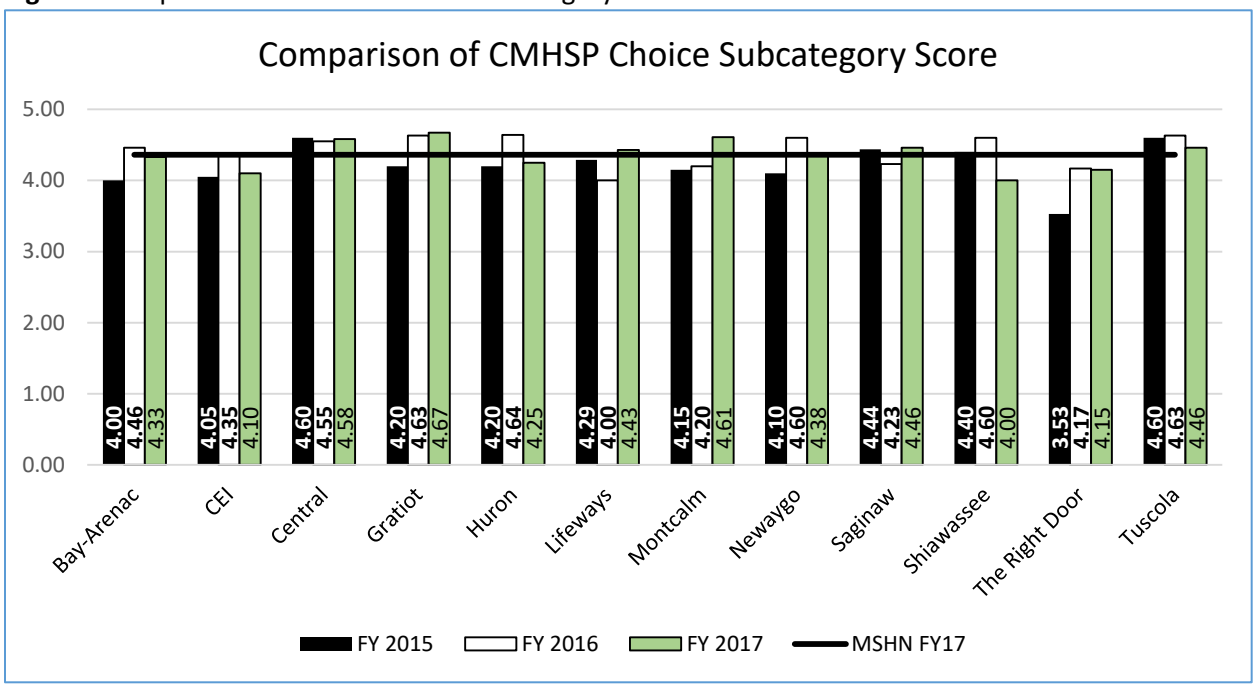


Figure 5 illustrates how each CMHSP scored in the Involvement subcategory. The MSHN average for FY 2015 was 3.42, 3.14 for FY 2016, and 3.64 for FY 2017.

Fig. 5 – Comparison of CMHSP Involvement Subcategory Score

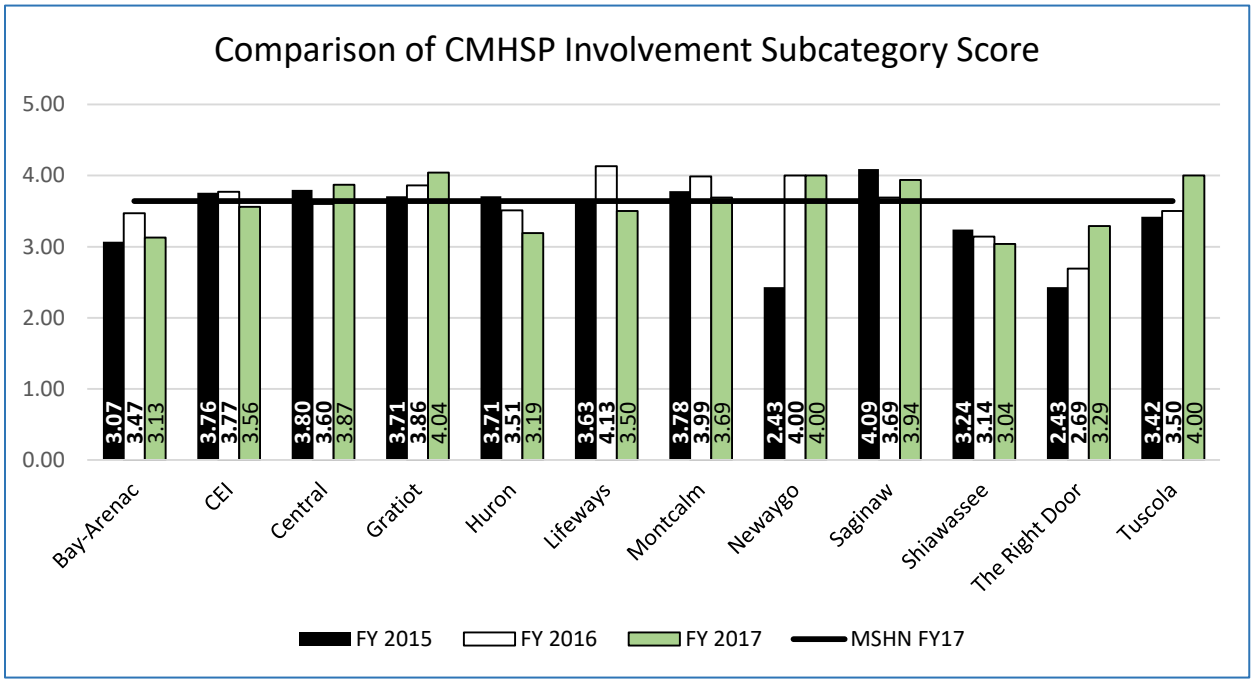


Figure 6 illustrates how each CMHSP scored in the Life Goals subcategory. The MSHN average for FY 2015 was 3.84, 4.09 for FY 2016, and 4.18 for FY 2017.

Fig. 6 – Comparison of CMHSP Life Goals Subcategory Score

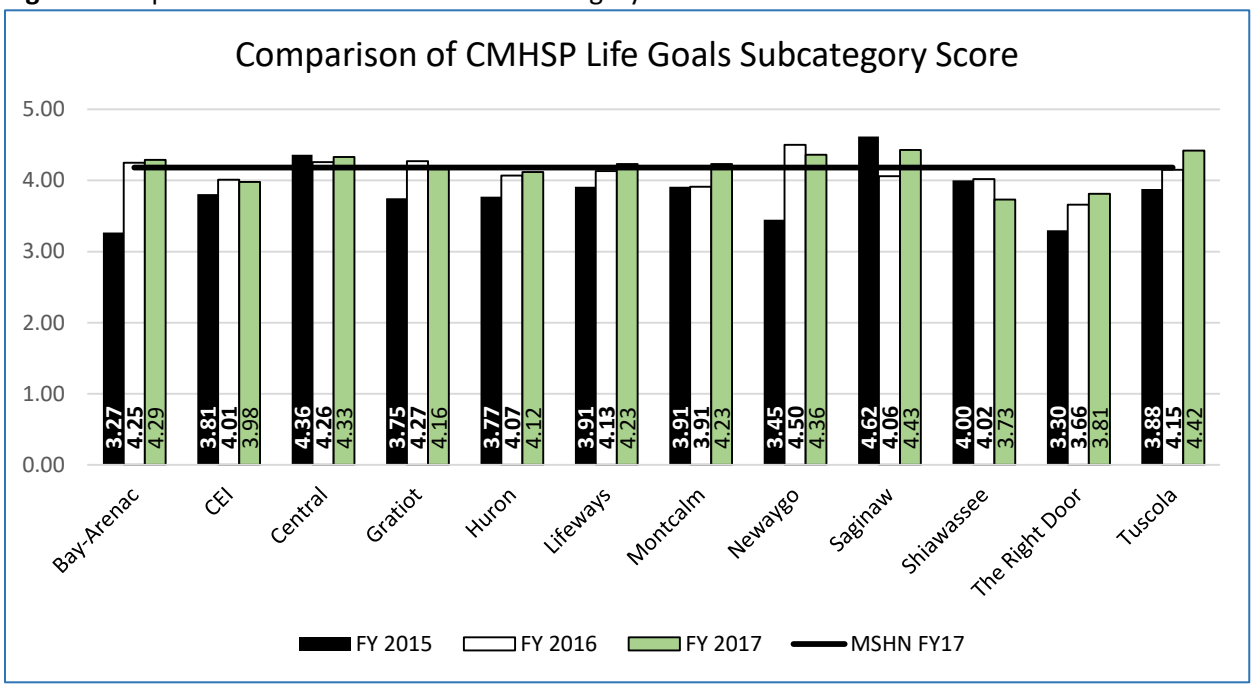


Figure 7 illustrates how each CMHSP scored in the Individually Tailored Services subcategory. The MSHN average for FY 2015 was 3.96, 4.05 for FY 2016., and 4.13 for FY 2017.

Fig. 7 – Comparison of CMHSP Individually Tailored Services Subcategory Score

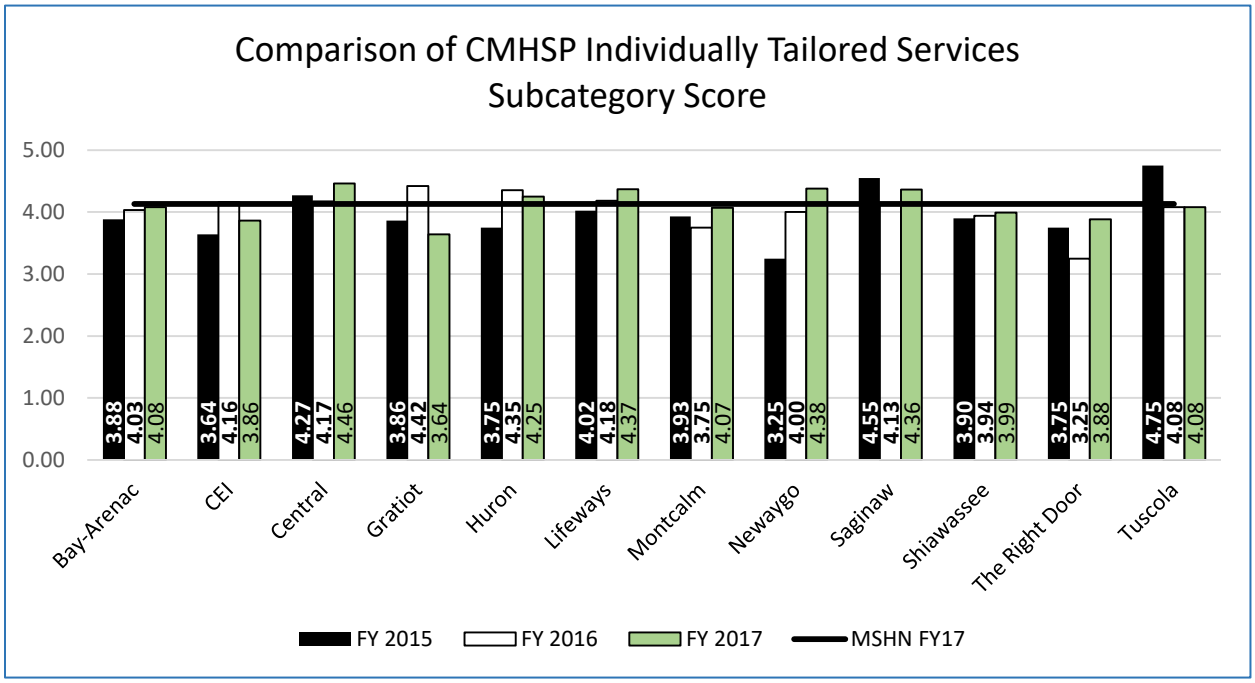
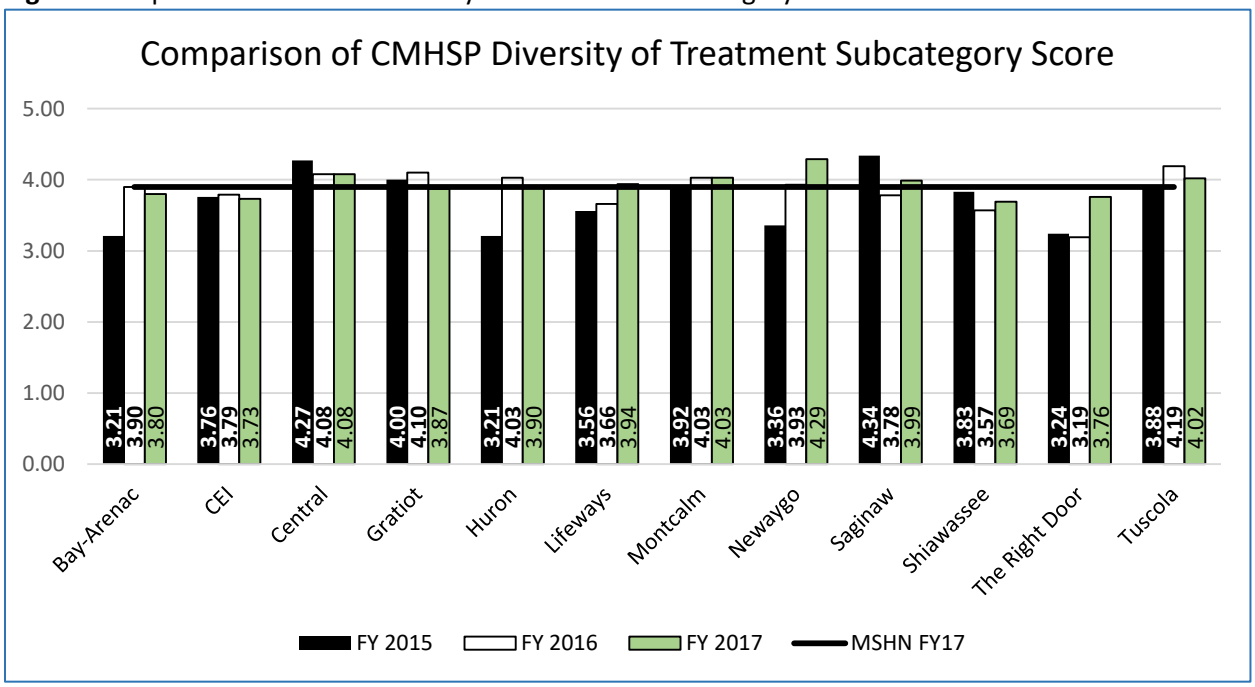


Figure 8 illustrates how each CMHSP scored in the Diversity of Treatment subcategory. The MSHN average for FY 2015 was 3.72, 3.84 for FY 2016, and 3.90 for FY 2017.

Fig. 8 – Comparison of CMHSP Diversity of Treatment Subcategory Score



MSHN Survey Response by Percentage

The Recovery Self-Assessment surveys were analyzed by subcategory questions and response. The "not applicable" and "do not know" responses were removed from the analysis. This analysis was performed by each CMHSP, and can be found at:
https://mshn.app.box.com/files/0/f/7338612889/CMHSP_RAS_aggregate_data

Figure 9 illustrates how all 12 CMHSPs responded to the two (2) Invite subcategory questions for FY 2015, FY 2016 and FY 2017. The questions included in Invite subcategory are as follows:

1: Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in programs.
2: This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).

Fig. 9 – MSHN – Invite Subcategory Survey Response by Percentage

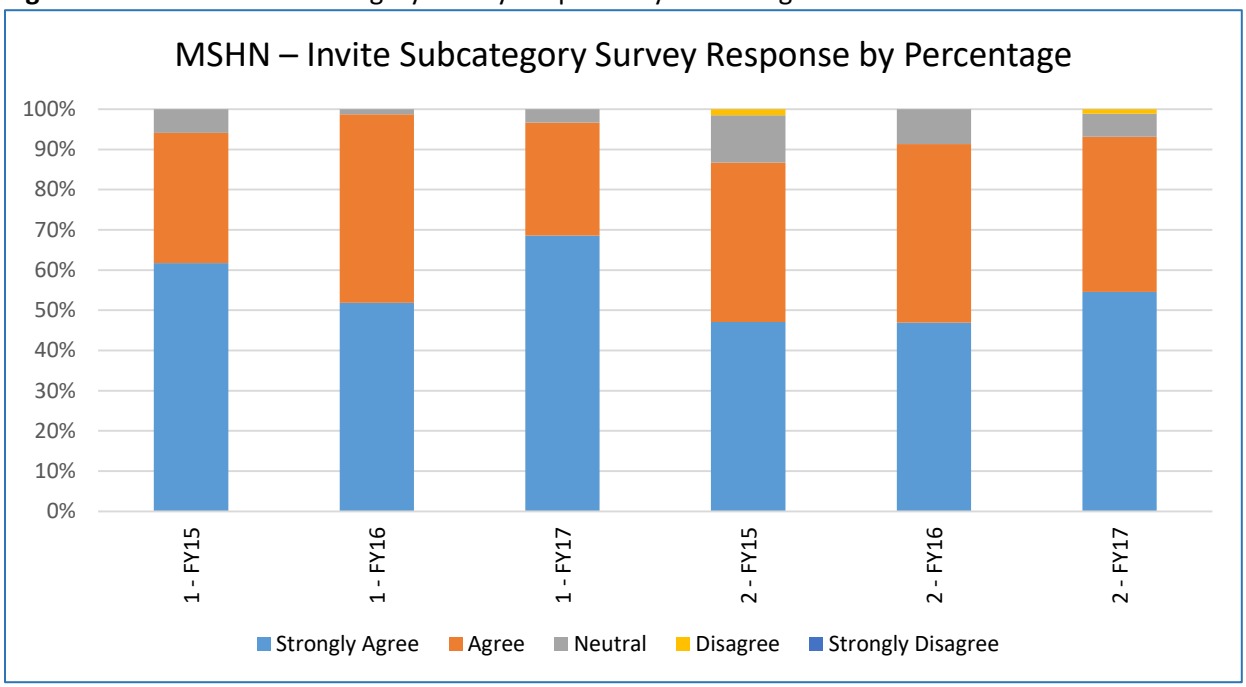


Figure 10 illustrates how all 12 CMHSPs responded to the four (4) Choice subcategory questions. The questions included in the Choice subcategory are as follows:

4: Program participants can change their clinician or case manager if they wish.
5: Program participants can easily access their treatment records if they wish.
6: Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.
10: Staff listen to and respect the decisions that program participants make about their treatment and care.

Fig. 10 – MSHN – Choice Subcategory Survey Response by Percentage

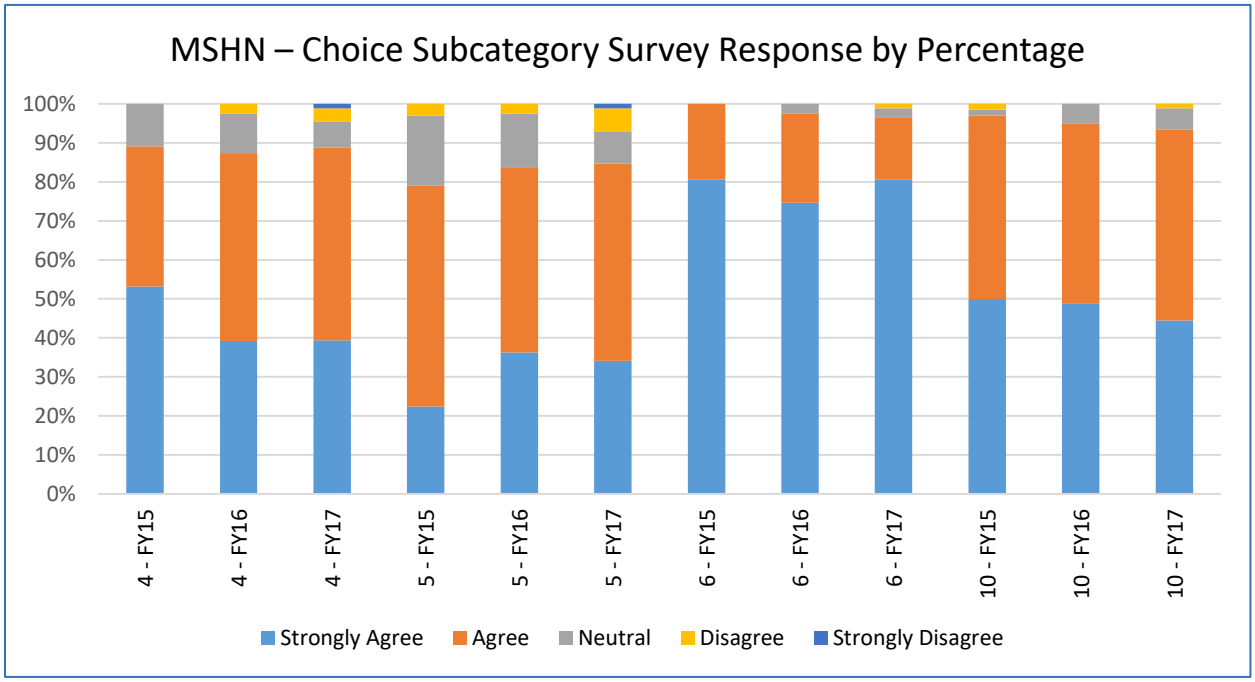


Figure 11 illustrates how all 12 CMHSPs responded to the seven (7) Involvement subcategory questions. The questions included in the Involvement subcategory are as follows:

22: Staff actively help people find ways to give back to their community (i.e., volunteering, community services, and neighborhood watch/cleanup).
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.
24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.
25. People in recovery are encouraged to attend agency advisory boards and management meetings.
29. Persons in recovery are involved with facilitating staff trainings and education at this program.
33. This agency provides formal opportunities for people in recovery, family members, service providers, and administrators to learn about recovery.
34. This agency provides structured educational activities to the community about mental illness and addictions.

Fig. 11 – MSHN – Involvement Subcategory Survey Response by Percentage

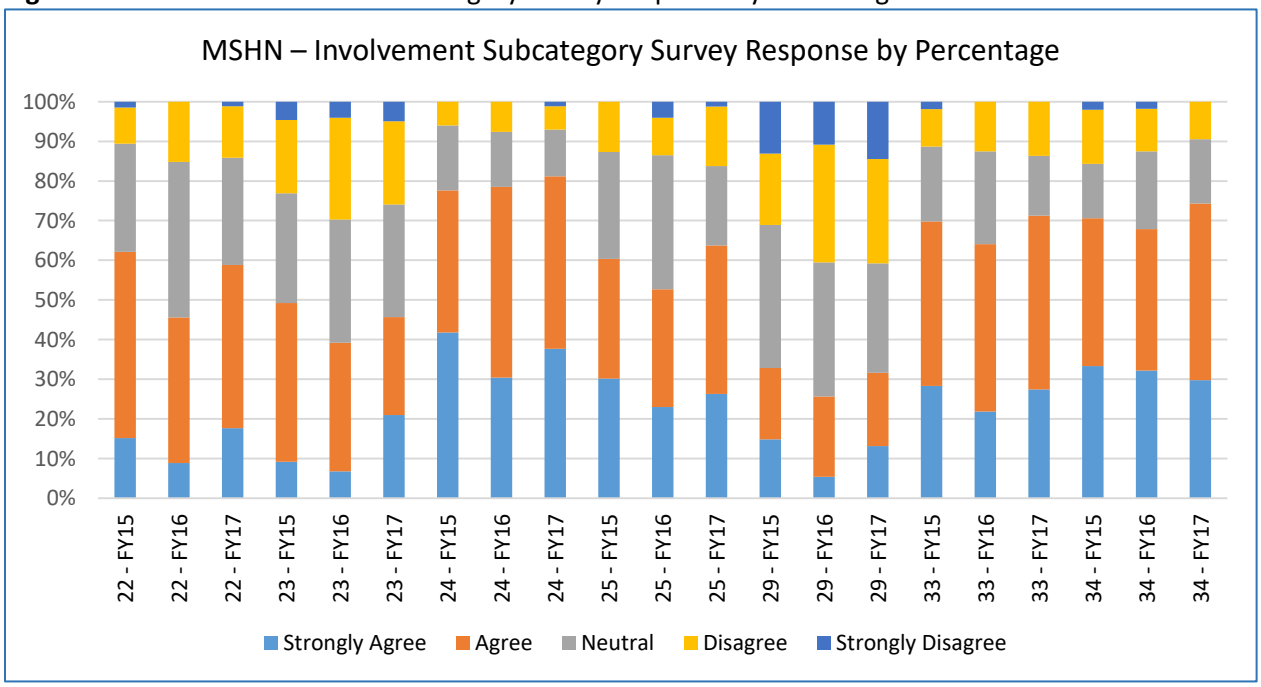


Figure 12 illustrates how all 12 CMHSPs responded to the eleven (11) Life Goals subcategory questions. The questions included in the Life Goals subcategory are as follows:

3. Staff encourage program participants to have hope and high expectations for their recovery.
7. Staff believe in the ability of program participants to recover.
8. Staff believe that program participants have the ability to manage their own symptoms.
9. Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.
12. Staff encourage program participants to take risks and try new things.
16. Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).
17. Staff routinely assist program participants with getting jobs.
18. Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.
28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.
31. Staff are knowledgeable about special interest groups and activities in the community.
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.

Fig. 12 – MSHN – Life Goals Subcategory Survey Response by Percentage

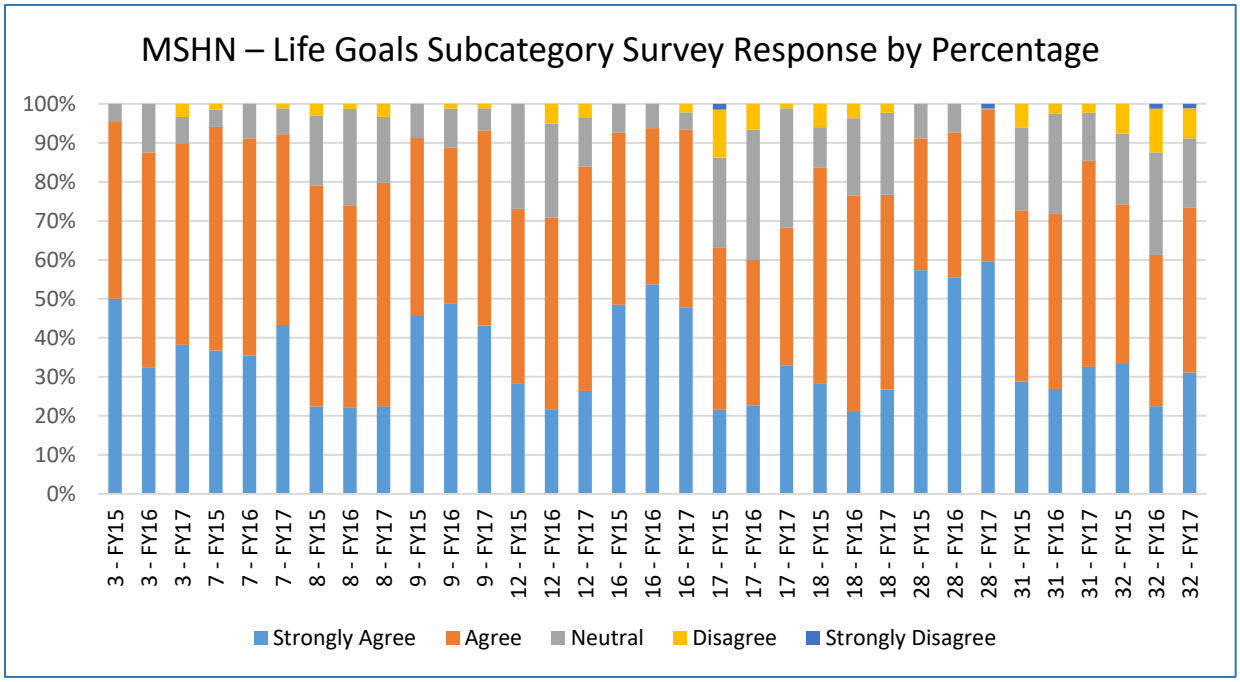


Figure 13 illustrates how all 12 CMHSPs responded to the four (4) Individually Tailored Service subcategory questions. The questions included in the Individually Tailored Service subcategory are as follows:

11. Staff regularly ask program participants about their interests and the things they would like to do in the community.
13. This program offers specific services that fit each participant's unique culture and life experiences.
19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).
30. Staff at this program regularly attend trainings on cultural competency.

Fig. 13 – MSHN – Individually Tailored Service Subcategory Survey Response by Percentage

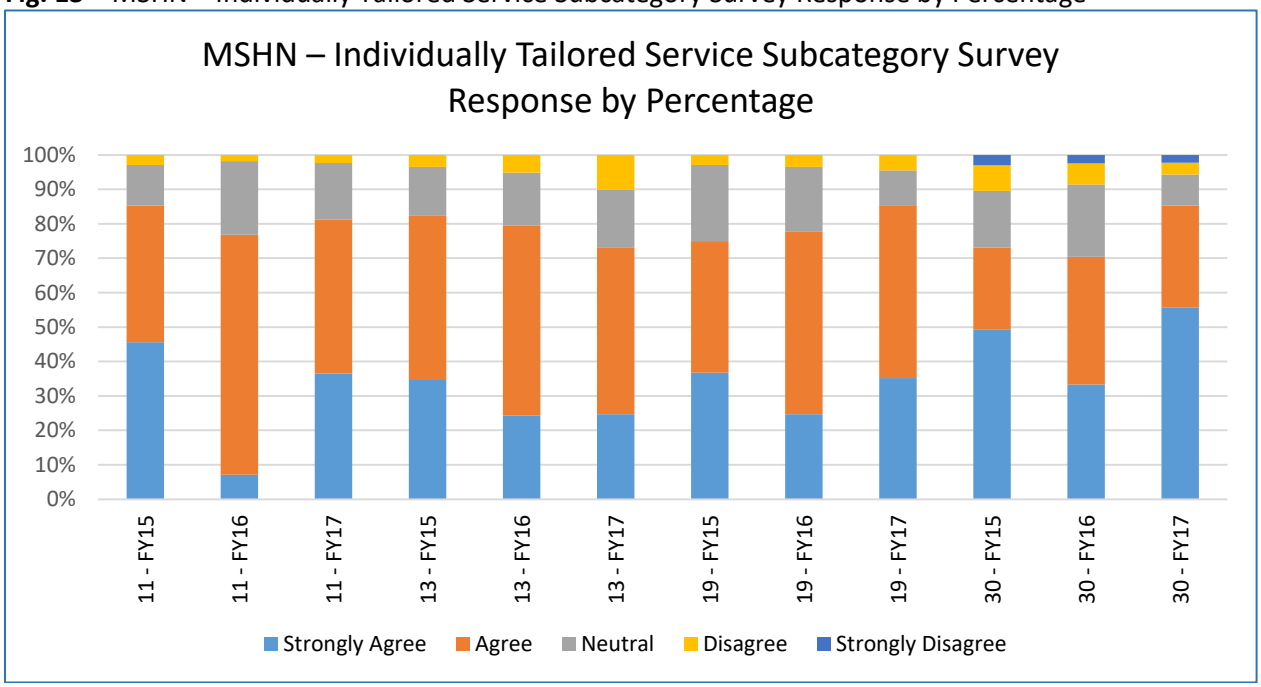
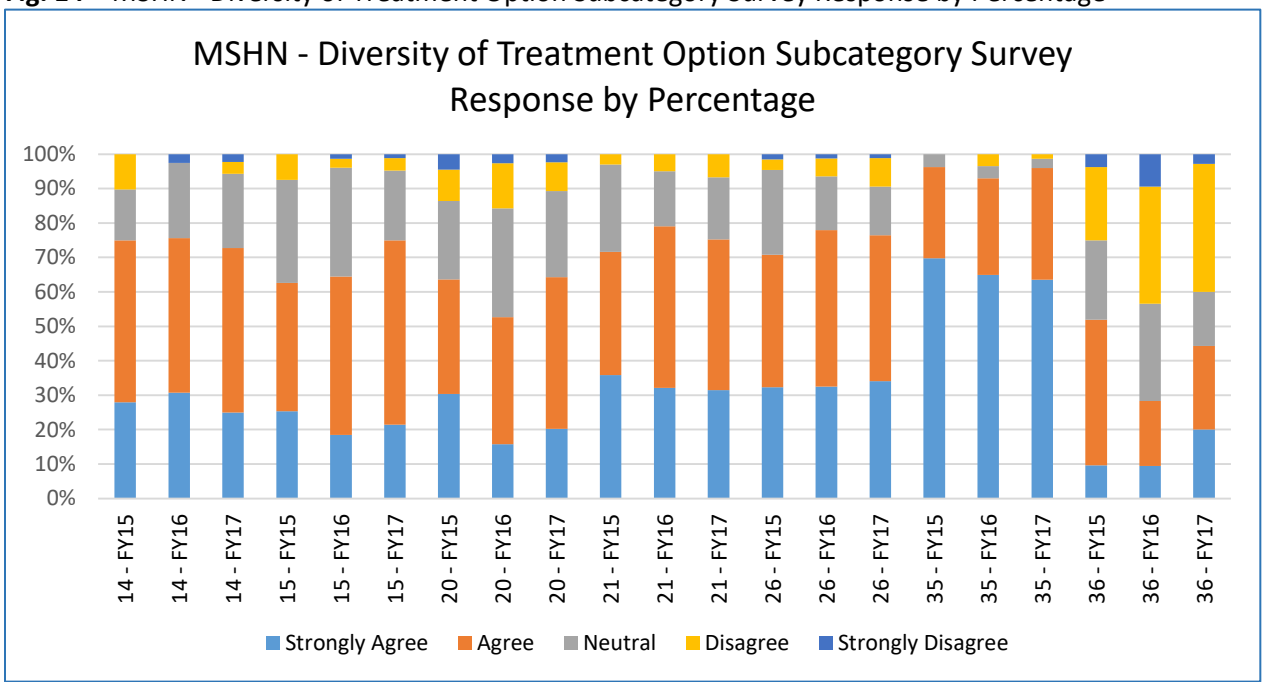


Figure 14 illustrates how all 12 CMHSP responded to the seven (7) Diversity of Treatment Option subcategory questions. The questions included in Diversity of Treatment Option subcategory are as follows:

14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.
15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.
20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.
21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.
26. Staff talk with program participants about what it takes to complete or exit the program.
35. This agency provides a variety of treatment options for program participants (e.g., individual, group, peer support, medical, community – based, employment, skill building, employment, etc.).
36. Groups, meetings, and other activities are scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.

Fig. 14 – MSHN - Diversity of Treatment Option Subcategory Survey Response by Percentage



Summary:

For the FY 2017 survey period there was an increase of 14 participants, 95 overall, who completed the survey from the FY 2016 participants of 81 and a 25 participant increase since FY 2015 participants of 70.

The survey consisted of six (6) separate subcategories that included Invite, Choice, Involvement, Life Goals, Individually Tailored Services and Diversity of Treatment. The comprehensive scores of all 12 CMHSP's for five (5) of the subcategories showed a slight increase in satisfaction from FY 2016 to FY 2017 and those subcategories included: Invite, Involvement, Life Goals, Individually Tailored Services and Diversity of Treatment. One (1) subcategory showed a slight decrease in satisfaction from FY 2016 to FY 2017 and that subcategory was Choice. The comprehensive score for all subcategories for MHSN went from 3.82 in FY 2015 to 4.00 in FY 2016 and increased again to 4.06 in FY 2017.

The subcategories showed the following changes in the MSHN average score when compared to FY 2016 to FY 2017:

Invite: 0.12 increase
Choice: 0.02 decrease
Involvement: 0.50 increase
Life Goals: 0.09 increase
Individually Tailored Services: 0.08 increase
Diversity of Treatment: 0.06 increase

The subcategory of "Involvement" showed the greatest increase in average score and the subcategory of "choice" showed a minimal decrease in the average score.

The comprehensive scores per each CMHSP also indicated that seven (7) CMHSP's showed a slight increase in scores from FY 2016 to FY 2017, and five (5) showed a slight decrease in scores.

The results will be reviewed further by the MSHN Quality Improvement Council to determine if there are any trends evident and if any regional improvement efforts would be recommended. Areas of improvement will be targeted toward below average scores (based on the regional average of all scores) and priority areas as identified through review by the Regional Consumer Advisory Council. Each CMHSP will also review their local results in all subcategories and identify any of local improvement recommendations.

Report Completed by: Mid-State Health Network **Date:** July 11, 2017

MSHN QIC Approved: July 27, 2017

VII. Consumer Satisfaction Reports – MHSIP

Introduction

The Michigan Department of Health and Human Services (MDHHS) requires a survey be administered annually to programs identified by the Michigan Quality Improvement Council. The Michigan QI Council has chosen the Assertive Community Treatment program as one of the programs for 2016. The program was required to complete the **Mental Health Statistics Improvement Program (MHSIP)** over a two-week period of time. MDHHS provides implementation guidelines and instructions to each Prepaid Inpatient Health Plan (PIHP). Each PIHP is to administer the survey within the time frame allotted by MDHHS. The survey results are returned to MDHHS via supplied excel workbook.

Each PIHP, in collaboration with the Community Mental Health Services Program (CMHSP) and their contracted providers, utilized the MHSIP to conduct a region wide perception of care survey to determine any areas that may be deficient within the region. The data obtained by each CMHSP was provided to Mid-State Health Network (MSHN) for regional analysis. The survey outcomes will be compared to the previous years Perception of Care Reports and is reported to MSHN's Quality Improvement Council (QIC).

Survey Response Rates

Clinicians within the Assertive Community Treatment program were given a tally form to track the survey response rate for their consumers. Those consumers who declined were removed from the total number of surveys distributed. The response rates were calculated by dividing the number of surveys that were received by the number of surveys that were distributed. **Figure 1** indicates the return rate for each CMHSP where data was available prior to February 26th. Any surveys received after February 26th were not included in the results.

Figure 1

	2013	2014	2015	2016			
MHSIP-ACT	Response Rates	Response Rates	Response Rates	Response Rates	Distributed	Received	Declined
MSHN	41%	34%	46%	**56%**	427	241	97
BAHB	41%	64%	59%	**29%**	42	12	18
CEI	44%	13%	46%	**47%**	45	21	24
CMHCM	55%	21%	28%	**81%**	102	83	11
GIHN	*	**	**	**	**	**	**
HBH	18%	23%	58%	**41%**	17	7	14
The Right Door	50%	*	**	**	**	**	**
Lifeways	23%	37%	43%	**42%**	118	49	7
MCN	26%	25%	40%	**27%**	22	6	8
NCMH	17%	*	**	**	**	**	**
Saginaw	85%	78%	88%	**60%**	42	25	7
Shiawassee	45%	38%	45%	**93%**	15	14	7
TBHS	87%	50%	52%	**100%**	24	24	1

*No Utilizers of ACT Services **No ACT Program

Methodology

The population type chosen was the Assertive Community Treatment (ACT) Team. The sample was a convenience sample of all who were scheduled to be seen within a pre-identified time frame. The Assertive Community Treatment (ACT) was given a choice of any two-week time frame from January 30th to February 26, 2017. All adult consumers within the ACT program received the MHSIP 44 survey. The raw data was required to be received by MDHHS no later than March 31, 2017. MDHHS will prepare an analysis, which includes comparison data of the PIHPs in Michigan and CMHSPs within each PIHP. Consumers did have the option to decline participation. If a consumer declined, this was noted and removed from the number distributed.

There were two optional changes in the implementation process that started in FY2012. Based on discussions with Substance Abuse and Mental Health Services Administration (SAMHSA) and information from other states that implement the MHSIP, the MDHHS QIC decided that PIHPs can opt to assign numerical identifiers to the MHSIP in order to identify the respondents. The PIHP was to use the selected field in the data entry forms to inform MDHHS whether they have chosen to assign identifiers. These identifiers are for the PIHPs use only, and are not to be shared with MDHHS. MSHN did not require the use of identifiers for the survey.

Scoring

MHSIP – Seven domains are included in the survey. Each domain has multiple questions related to the domain topic. The domains are as follows: general satisfaction, access to care, quality of care, participation in treatment, outcomes of care, functional status, and social connectedness. Each question in the domain is required to have a response choice of 1 - 5 in order for the domain to be included in the sample. If one question is left blank, the responses of the remaining questions for that domain are excluded from the calculations of that domain. There are 6 response choices for each question within the domain, which are assigned a numeric value. Note that the number of responses included in the domain average and domain percentage of agreement could be less than that of each individual question as a result of the exclusion of unanswered questions when calculating the domain.

Strongly Agree=1
Agree=2
Neutral=3
Disagree=4
Strongly Disagree=5
Not Applicable=9

The mean of each individual question is calculated. Those less than or equal to 2.5 are considered to be "in agreement". The total number of respondents who were "in agreement" is then divided by the total respondents. The resultant number is then multiplied by 100 to provide a percentage. Those questions that have a "Blank" or a response of "Not Applicable" were removed from the sample.

The logic for Fiscal Year 2016 was updated to include steps that the state utilizes to calculate the domain percentage scores that were not originally included in the Scoring Protocols provided by the state. MSHN QIC decided to adopt these changes following Fiscal Year 2015. The Scoring Protocols are as follows: individuals who are missing more than 1/3 of total responses (blanks, or invalid response) are removed completely from the report for calculating subscale scores. Also within the subscales, if an individual is missing 1 or more of the included questions (blanks, or invalid responses) they are removed completely from the subscale scoring for that specific subscale. (The individuals' valid responses are not removed from calculating the response totals to individual questions in Attachment A; even if they were removed from the subscale).

Data Analysis

Each survey was entered into an excel spreadsheet. The ACT program was categorized by numeric codes provided by MDHHS.

The results are analyzed as follows:

PIHP

- By Domain
- By Domain Line Item

CMHSP (Attachment A - MHSIP)

- By Domain
- By Domain Line Item

Survey Findings

MHSIP

Figure 2 demonstrates the percentage of agreement for each domain. Please refer to the scoring methodology above with questions related to the calculations. Each domain scored above the desired threshold of 80% except the "Perception of Outcome of Services", "Perception of Functioning", "Perception of Social Connectedness", and "Perception of Participation in Treatment". MSHN scored the highest in the "Perception of Quality and Appropriateness", "Perception of Access," and "General Satisfaction" domains in that order. Those who responded to the survey indicated:

a) Staff gave Respondents the information needed to manage their illness (Survey Q19 – 82%, 193/234)
b) Staff gave Respondents information about their rights (Survey Q13 – 90%, 213/237)
c) Respondents were able to take responsibility for how to live their lives (Survey Q14 – 86%, 201/235)
d) Staff were willing to see Respondents as often as was necessary (Survey Q5 – 89%, 211/237)
e) Staff respected Respondents' wishes about who to and not to give Respondents' information to (Survey Q16 – 89%, 208/234)
f) Staff believed Respondents could grow, change and recover (Survey Q10 – 86%, 201/234)
g) Staff encouraged Respondents to use consumer run programs (Survey Q20 – 80%, 187/235)
h) Respondents felt comfortable asking questions about their treatment (Survey Q11 – 88%, 209/237)
i) Staff were able to see Respondents at times that were good for Respondents (Survey Q7 – 88%, 207/235)
j) Staff returned calls within 24 hours (Survey Q6 – 84%, 199/237)
k) Respondents liked the services they received (Survey Q1 – 86%, 202/236)
l) Respondents would recommend the agency to a friend or family member (Survey Q3 – 82%, 193/235).

Adult Survey	General Satisfaction				Perception of Access				Perception of Quality and Appropriateness				Perception of Participation in Treatment Planning			
	2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016
MSHN	86%	90%	85%	**83%**	91%	92%	86%	**86%**	89%	97%	85%	**91%**	86%	94%	84%	**78%**
BABH	84%	71%	84%	**91%**	92%	79%	92%	**91%**	91%	89%	86%	**91%**	92%	90%	87%	**91%**
CEI	79%	100%	90%	**83%**	83%	100%	89%	**89%**	82%	100%	89%	**100%**	72%	100%	90%	**70%**
CMHCM	89%	86%	73%	**79%**	98%	91%	82%	**87%**	86%	95%	78%	**89%**	90%	90%	83%	**78%**
HBH	89%	100%	91%	**100%**	88%	86%	89%	**86%**	89%	100%	93%	**100%**	88%	100%	95%	**71%**
The Right Door	100%	*	**	**	100%	*	**	**	100%	*	**	**	100%	*	**	**
Lifeways	86%	90%	86%	**79%**	94%	97%	83%	**79%**	89%	98%	84%	**90%**	82%	97%	82%	**77%**
MCN	100%	100%	73%	**100%**	80%	100%	69%	**80%**	100%	100%	76%	**100%**	100%	100%	65%	**67%**
NCMH	75%	*	**	**	100%	*	**	**	100%	*	**	**	100%	*	**	**
Saginaw	94%	95%	92%	**80%**	88%	95%	93%	**83%**	91%	100%	89%	**83%**	85%	95%	85%	**76%**
Shiawassee	80%	100%	78%	**93%**	90%	67%	88%	**85%**	89%	100%	84%	**92%**	80%	88%	83%	**79%**
TBHS	72%	90%	86%	**92%**	85%	80%	86%	**96%**	86%	78%	88%	**91%**	81%	80%	88%	**87%**

Adult Survey	Perception of Outcome of Services				Perception of Functioning				Perception of Social Connectedness			
	2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016
MSHN	73%	84%	74%	**68%**	84%	73%	75%	**69%**	84%	82%	77%	**66%**
BABH	72%	50%	76%	**57%**	96%	60%	72%	**73%**	92%	73%	73%	**73%**
CEI	73%	100%	86%	**78%**	79%	88%	82%	**63%**	94%	100%	77%	**61%**
CMHCM	74%	92%	66%	**75%**	83%	89%	67%	**74%**	84%	68%	74%	**66%**
HBH	83%	75%	86%	**71%**	88%	67%	82%	**71%**	100%	50%	84%	**71%**
The Right Door	100%	*	**	**	100%	*	**	**	67%	*	**	**
Lifeways	82%	86%	75%	**50%**	87%	71%	75%	**63%**	78%	86%	75%	**61%**
MCN	50%	100%	67%	**50%**	60%	80%	68%	**80%**	100%	80%	65%	**33%**
NCMH	67%	*	**	**	33%	*	**	**	67%	*	**	**
Saginaw	80%	92%	77%	**79%**	90%	86%	79%	**80%**	88%	95%	87%	**75%**
Shiawassee	86%	67%	70%	**67%**	100%	33%	77%	**46%**	89%	100%	83%	**57%**
TBHS	44%	57%	66%	**69%**	68%	60%	68%	**65%**	69%	60%	68%	**74%**

Figure 3 provides a comparison of the percentage of those who responded with "agree-2" or "strongly agree-1" for each question within the domain. Please refer to the scoring methodology above with questions related to the calculations.

Figure 3

Adult – ACT Program	2013	2014	2015	2016
General Satisfaction				
Q1. I like the services that I received.	87.6%	92%	89%	**86%**
Q2. If I had other choices, I would still choose to get services from this mental health agency.	83.4%	84%	83%	**81%**
Q3. I would recommend this agency to a friend or family member.	84.0%	91%	83%	**82%**
Perception of Access				
Q4. The location of services was convenient.	82.7%	87%	85%	**82%**
Q5. Staff were willing to see me as often as I felt it was necessary.	90.6%	89%	88%	**89%**
Q6. Staff returned my calls within 24 hours.	85.8%	90%	90%	**84%**
Q7. Services were available at times that were good for me.	88.3%	91%	87%	**88%**
Q8. I was able to get all the services I thought I needed.	83.7%	87%	84%	**83%**
Q9. I was able to see a psychiatrist when I wanted to.	79.8%	83%	80%	**79%**
Perception of Quality and Appropriateness				
Q10. Staff believed that I could grow, change and recover.	86.9%	91%	88%	**86%**
Q12. I felt free to complain.	79.4%	85%	77%	**79%**
Q13. I was given information about my rights.	89.7%	91%	90%	**90%**
Q14. Staff encouraged me to take responsibility for how I live my life.	87.7%	92%	88%	**86%**
Q15. Staff told me what side effects to watch for.	78.4%	84%	79%	**75%**
Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	86.8%	92%	88%	**89%**
Q18. Staff were sensitive to my cultural/ ethnic background (e.g., race, religion, language, etc.).	82.1%	91%	81%	**79%**
Q19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	87.7%	90%	88%	**82%**
Q20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	83.9%	93%	84%	**80%**
Perception of Participation in Treatment Planning				
Q11. I felt comfortable asking questions about my treatment, services, and medication.	86.0%	93%	89%	**88%**
Q17. I, not staff, decided my treatment goals.	79.5%	87%	80%	**79%**
Perception of Outcome of Services				
Q21. I deal more effectively with daily problems.	80.4%	84%	82%	**77%**
Q22. I am better able to control my life.	80.6%	82%	79%	**78%**
Q23. I am better able to deal with crisis.	75.8%	79%	77%	**76%**
Q24. I am getting along better with my family.	78.2%	74%	76%	**69%**
Q25. I do better in social situations.	68.3%	70%	78%	**63%**
Q26. I do better in school and/or work.	57.8%	61%	60%	**35%**
Q27. My housing situation has improved.	68.6%	76%	73%	**64%**
Q28. My symptoms are not bothering me as much.	70.8%	66%	72%	**66%**

Perception of Functioning				
Q29. I do things that are more meaningful to me.	80.2%	75%	75%	**74%**
Q30. I am better able to take care of my needs.	82.0%	79%	81%	**75%**
Q31. I am better able to handle things when they go wrong.	73.7%	72%	74%	**71%**
Q32. I am better able to do things that I want to do.	78.7%	77%	72%	**71%**
Perception of Social Connectedness				
Q33. I am happy with the friendships I have.	84.9%	77%	81%	**68%**
Q34. I have people with who I can do enjoyable things.	80.3%	79%	82%	**71%**
Q35. I feel I belong in my community.	70.5%	70%	70%	**62%**
Q36. In a crisis, I would have the support I need from family or friends.	81.1%	79%	74%	**73%**

Recommendations/Improvement Opportunities

The results will be reviewed by the MSHN Quality Improvement Council and the Regional Consumer Advisory Council to determine possible region wide improvement efforts as well as identification of any trends that have occurred from year to year. The results will be compared to national averages as available. The areas of improvement will be targeted towards the domains with the lower average scores (based on the regional average of all scores) and those domains that have shown a decrease from the previous years. Each CMHSP will also review their local results for areas of improvement at the local level. It is also recommended that those with a low number of returned responses review their process and determine if additional action may need to be taken to impact the response rate. The low number of responses may result in an acceptable threshold based on the standard set or it may result in an unacceptable threshold. The low numbers may also impact the ability for the results to be generalized throughout the population.

Completed by: MSHN

Date: May 2017

Revised: June 2017 & July 2017

MSHN QIC Approved: 06/22/17

Adult Survey		MSHN	BABH	CEI	CMCMH	HBH	Lifeways	MCN	Saginaw	Shiawassee	TBHS
General Satisfaction	**Domain Average %**	**83%**	**91%**	**83%**	**79%**	**100%**	**79%**	**100%**	**80%**	**93%**	**92%**
1. I like the services that I received.	% Agreement	**86%**	**91%**	**85%**	**79%**	**100%**	**83%**	**100%**	**88%**	**93%**	**96%**
	# Agree	202	10	17	65	7	40	5	22	13	23
	# Valid Respondents	236	11	20	82	7	48	5	25	14	24
2. If I had other choices, I would still choose to get services from this mental healthcare agency.	% Agreement	**81%**	**73%**	**80%**	**78%**	**86%**	**81%**	**100%**	**80%**	**86%**	**92%**
	# Agree	191	8	16	64	6	38	5	20	12	22
	# Valid Respondents	235	11	20	82	7	47	5	25	14	24
3. I would recommend this agency to a friend or family member.	% Agreement	**82%**	**100%**	**75%**	**82%**	**86%**	**77%**	**100%**	**84%**	**64%**	**96%**
	# Agree	193	11	15	67	6	36	5	21	9	23
	# Valid Respondents	235	11	20	82	7	47	5	25	14	24
Perception of Access	**Domain Average %**	**86%**	**91%**	**89%**	**87%**	**86%**	**79%**	**80%**	**83%**	**85%**	**96%**
4. The location of services was convenient.	% Agreement	**82%**	**91%**	**85%**	**82%**	**100%**	**81%**	**67%**	**72%**	**86%**	**83%**
	# Agree	194	10	17	67	7	39	4	18	12	20
	# Valid Respondents	237	11	20	82	7	48	6	25	14	24
5. Staff were willing to see me as often as I felt it was necessary.	% Agreement	**89%**	**91%**	**85%**	**91%**	**100%**	**85%**	**83%**	**80%**	**86%**	**100%**
	# Agree	211	10	17	75	7	41	5	20	12	24
	# Valid Respondents	237	11	20	82	7	48	6	25	14	24
6. Staff returned my calls within 24 hours.	% Agreement	**84%**	**82%**	**75%**	**85%**	**71%**	**77%**	**100%**	**80%**	**93%**	**100%**
	# Agree	199	9	15	70	5	37	6	20	13	24

	# Valid Respondents	237	11	20	82	7	48	6	25	14	24
7. Services were available at times that were good for me.	% Agreement	**88%**	**100%**	**85%**	**93%**	**86%**	**79%**	**100%**	**84%**	**79%**	**96%**
	# Agree	207	11	17	75	6	38	5	21	11	23
	# Valid Respondents	235	11	20	81	7	48	5	25	14	24
8. I was able to get all the services I thought I needed.	% Agreement	**83%**	**100%**	**75%**	**83%**	**86%**	**75%**	**83%**	**84%**	**71%**	**100%**
	# Agree	196	11	15	68	6	36	5	21	10	24
	# Valid Respondents	237	11	20	82	7	48	6	25	14	24
9. I was able to see a psychiatrist when I wanted to.	% Agreement	**79%**	**73%**	**85%**	**73%**	**100%**	**81%**	**83%**	**72%**	**79%**	**92%**
	# Agree	187	8	17	60	7	39	5	18	11	22
	# Valid Respondents	237	11	20	82	7	48	6	25	14	24
Perception of Quality and Appropriateness	**Domain Average %**	**91%**	**91%**	**100%**	**89%**	**100%**	**90%**	**100%**	**83%**	**92%**	**91%**
10. Staff believed that I could grow, change and recover.	% Agreement	**86%**	**73%**	**75%**	**85%**	**100%**	**89%**	**80%**	**80%**	**86%**	**100%**
	# Agree	201	8	15	70	7	41	4	20	12	24
	# Valid Respondents	234	11	20	82	7	46	5	25	14	24
12. I felt free to complain.	% Agreement	**79%**	**82%**	**72%**	**85%**	**57%**	**79%**	**50%**	**64%**	**71%**	**96%**
	# Agree	185	9	13	69	4	38	3	16	10	23
	# Valid Respondents	234	11	18	81	7	48	6	25	14	24
13. I was given information about my rights.	% Agreement	**90%**	**100%**	**75%**	**90%**	**100%**	**92%**	**100%**	**84%**	**86%**	**96%**
	# Agree	213	11	15	74	7	44	6	21	12	23
	# Valid Respondents	237	11	20	82	7	48	6	25	14	24

14. Staff encouraged me to take responsibility for how I live my life.	% Agreement	**86%**	**73%**	**80%**	**88%**	**57%**	**91%**	**80%**	**84%**	**79%**	**92%**
	# Agree	201	8	16	72	4	43	4	21	11	22
	# Valid Respondents	235	11	20	82	7	47	5	25	14	24
15. Staff told me what side effects to watch for.	% Agreement	**75%**	**82%**	**60%**	**79%**	**71%**	**73%**	**50%**	**76%**	**79%**	**79%**
	# Agree	178	9	12	65	5	35	3	19	11	19
	# Valid Respondents	237	11	20	82	7	48	6	25	14	24
16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	% Agreement	**89%**	**91%**	**80%**	**93%**	**86%**	**79%**	**100%**	**88%**	**93%**	**100%**
	# Agree	208	10	16	75	6	37	5	22	13	24
	# Valid Respondents	234	11	20	81	7	47	5	25	14	24
18. Staff were sensitive to my cultural/ethnic background (e.g., race, religion, language, etc.).	% Agreement	**79%**	**91%**	**70%**	**75%**	**100%**	**81%**	**60%**	**76%**	**93%**	**88%**
	# Agree	184	10	14	59	7	38	3	19	13	21
	# Valid Respondents	232	11	20	79	7	47	5	25	14	24
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	% Agreement	**82%**	**91%**	**79%**	**85%**	**100%**	**77%**	**83%**	**76%**	**71%**	**92%**
	# Agree	193	10	15	68	7	37	5	19	10	22
	# Valid Respondents	234	11	19	80	7	48	6	25	14	24
20. I was encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line, etc.).	% Agreement	**80%**	**64%**	**65%**	**75%**	**86%**	**81%**	**80%**	**88%**	**93%**	**92%**
	# Agree	187	7	13	61	6	39	4	22	13	22
	# Valid Respondents	235	11	20	81	7	48	5	25	14	24

Participation in Treatment Planning	Domain Average %	78%	91%	70%	78%	71%	77%	67%	76%	79%	87%
11. I felt comfortable asking questions about my treatment, services and medication.	% Agreement	88%	100%	85%	89%	100%	83%	100%	84%	79%	96%
	# Agree	209	11	17	73	7	40	6	21	11	23
	# Valid Respondents	237	11	20	82	7	48	6	25	14	24
17. I, not staff, decided my treatment goals.	% Agreement	79%	91%	70%	80%	71%	81%	67%	80%	79%	79%
	# Agree	187	10	14	65	5	39	4	20	11	19
	# Valid Respondents	236	11	20	81	7	48	6	25	14	24
Perception of Outcome of Services	**Domain Average %**	**68%**	**57%**	**78%**	**75%**	**71%**	**50%**	**50%**	**79%**	**67%**	**69%**
21. I deal more effectively with daily problems.	% Agreement	77%	73%	75%	82%	100%	72%	67%	72%	57%	83%
	# Agree	180	8	15	67	7	34	4	18	8	19
	# Valid Respondents	235	11	20	82	7	47	6	25	14	23
22. I am better able to control my life.	% Agreement	78%	91%	75%	80%	86%	72%	80%	71%	71%	87%
	# Agree	181	10	15	65	6	34	4	17	10	20
	# Valid Respondents	232	11	20	81	7	47	5	24	14	23
23. I am better able to deal with crisis.	% Agreement	76%	91%	65%	3%	57%	69%	83%	75%	79%	74%
	# Agree	179	10	13	86	4	33	5	18	11	17
	# Valid Respondents	235	11	20	82	7	48	6	24	14	23
24. I am getting along better with my family.	% Agreement	69%	91%	60%	75%	71%	58%	67%	68%	64%	70%
	# Agree	162	10	12	61	5	28	4	17	9	16
	# Valid Respondents	235	11	20	81	7	48	6	25	14	23

25. I do better in social situations.	% Agreement	**63%**	**55%**	**60%**	**68%**	**43%**	**50%**	**67%**	**84%**	**71%**	**57%**
	# Agree	148	6	12	55	3	24	4	21	10	13
	# Valid Respondents	235	11	20	81	7	48	6	25	14	23
26. I do better in school and/or work.	% Agreement	**35%**	**36%**	**20%**	**39%**	**43%**	**25%**	**0%**	**42%**	**50%**	**39%**
	# Agree	80	4	4	32	3	11	0	10	7	9
	# Valid Respondents	231	11	20	82	7	44	6	24	14	23
27. My housing situation has improved.	% Agreement	**64%**	**55%**	**70%**	**70%**	**86%**	**53%**	**50%**	**64%**	**71%**	**57%**
	# Agree	148	6	14	55	6	25	3	16	10	13
	# Valid Respondents	232	11	20	79	7	47	6	25	14	23
28. My symptoms are not bothering me as much. (Outcomes)	% Agreement	**66%**	**82%**	**75%**	**72%**	**71%**	**48%**	**67%**	**72%**	**50%**	**65%**
	# Agree	155	9	15	59	5	23	4	18	7	15
	# Valid Respondents	236	11	20	82	7	48	6	25	14	23
Perception of Functioning	**Domain Average %**	**69%**	**73%**	**63%**	**74%**	**71%**	**63%**	**80%**	**80%**	**46%**	**65%**
29. I do things that are more meaningful to me.	% Agreement	**74%**	**82%**	**75%**	**74%**	**86%**	**64%**	**83%**	**80%**	**64%**	**83%**
	# Agree	173	9	15	60	6	30	5	20	9	19
	# Valid Respondents	234	11	20	81	7	47	6	25	14	23
30. I am better able to take care of my needs.	% Agreement	**75%**	**73%**	**70%**	**78%**	**86%**	**75%**	**67%**	**76%**	**64%**	**70%**
	# Agree	176	8	14	64	6	36	4	19	9	16
	# Valid Respondents	236	11	20	82	7	48	6	25	14	23
31. I am better able to handle things when they go wrong.	% Agreement	**71%**	**73%**	**75%**	**74%**	**71%**	**69%**	**67%**	**72%**	**57%**	**65%**

	# Agree	167	8	15	61	5	33	4	18	8	15
	# Valid Respondents	236	11	20	82	7	48	6	25	14	23
32. I am better able to do things that I want to do.	% Agreement	**71%**	**82%**	**78%**	**76%**	**57%**	**66%**	**67%**	**72%**	**54%**	**70%**
	# Agree	165	9	14	62	4	31	4	18	7	16
	# Valid Respondents	232	11	18	82	7	47	6	25	13	23
Perception of Social Connectedness	**Domain Average %**	**66%**	**73%**	**61%**	**66%**	**71%**	**61%**	**33%**	**75%**	**57%**	**74%**
33. I am happy with the friendships I have.	% Agreement	**68%**	**73%**	**70%**	**66%**	**86%**	**62%**	**50%**	**75%**	**71%**	**71%**
	# Agree	158	8	14	54	6	28	3	18	10	17
	# Valid Respondents	233	11	20	82	7	45	6	24	14	24
34. I have people with who I can do enjoyable things.	% Agreement	**71%**	**73%**	**65%**	**69%**	**86%**	**67%**	**50%**	**83%**	**71%**	**75%**
	# Agree	164	8	13	56	6	30	3	20	10	18
	# Valid Respondents	232	11	20	81	7	45	6	24	14	24
35. I feel I belong in my community.	% Agreement	**62%**	**82%**	**70%**	**63%**	**71%**	**49%**	**50%**	**63%**	**64%**	**67%**
	# Agree	145	9	14	52	5	22	3	15	9	16
	# Valid Respondents	233	11	20	82	7	45	6	24	14	24
36. In a crisis, I would have the support I need from family or friends.	% Agreement	**73%**	**64%**	**85%**	**77%**	**71%**	**9%**	**67%**	**67%**	**57%**	**79%**
	# Agree	170	7	17	63	5	31	4	16	8	19
	# Valid Respondents	233	11	20	82	7	45	6	24	14	24

VIII. Consumer Satisfaction Reports – YSS

Quality Assessment and Performance Improvement Program
2015 Perception of Care Report
Home-Based Services Program

Introduction

The Michigan Department of Health and Human Services (MDHHS) requires a survey be administered annually to programs identified by the Michigan Quality Improvement (QI) Council. The Michigan QI Council has chosen the Home-Based Services program as one of the programs for 2016. The program completed the Youth Satisfaction Survey for Families (YSSF) over a two-week period of time. MDHHS provides implementation guidelines and instructions to each Prepaid Inpatient Health Plan (PIHP). Each PIHP is to administer the survey within the time frame allotted by MDHHS. The survey results are returned to MDHHS via a supplied excel workbook.

Each PIHP, in collaboration with the Community Mental Health Services Program (CMHSP) and their contracted providers, utilized the YSSF to conduct a region wide perception of care survey to determine any areas that may be deficient within the region. The data obtained by each CMHSP was provided to Mid-State Health Network (MSHN) for regional analysis. The survey outcomes will be compared to the previous years Perception of Care Reports and is reported to MSHN's Quality Improvement Council (QIC).

Survey Response Rates

Clinicians within the Home-Based Services program were given a tally form to track the survey response rate for their consumers. Consumers were given an option to decline answering the survey questions. Those consumers who declined were removed from the total number of surveys distributed. The response rates were calculated by dividing the number of surveys that were received by the number of surveys that were distributed.

Figure 1 indicates the return rate for each CMHSP where data was available prior to February 26th. Any surveys received after February 26th were not included in the results.

Figure 1

	2013	2014	2015	2016			
YSSF Home-Based Services	**Response Rates**	**Response Rates**	**Response Rates**	**Response Rates**	**Distributed**	**Received**	**Declined**
MSHN	32%	22%	40%	33%	1226	405	68
BABH	15%	28%	15%	30%	63	19	2
CEI	37%	9%	63%	10%	532	55	0
CMHCM	24%	31%	41%	39%	157	61	11
GIHN	95%	42%	31%	70%	44	31	12
HBH	10%	100%	38%	41%	17	7	6
The Right Door	*	52%	35%	46%	50	23	0
Lifeways	15%	34%	33%	36%	218	78	15
MCN	20%	32%	34%	39%	75	29	2
NCMH	*	100%	21%	23%	22	5	17
Saginaw	13%	59%	30%	29%	7	2	0
Shiawassee	43%	10%	40%	79%	28	22	1
TBHS	56%	56%	77%	75%	68	51	2

* No data available

Methodology

The sample was a convenience sample of all who were scheduled to be seen within a pre-identified time frame. The Home-Based Services (HBS) survey population was given a choice of any two-week time frame from January 30th to February 26, 2017. The Youth, 17 years and younger, who were receiving services from the Home-Based Services program received the YSSF-36 survey. The raw data was required to be received by MDHHS no later than March 31, 2017. MDHHS will prepare an analysis, which will include comparison data of PIHPs in Michigan and CMHSPs within each PIHP. Consumers did have the option to decline participation. If a consumer declined, this was noted and removed from the number distributed.

There were two optional changes in the implementation process that were implemented starting in FY2012. Based on discussions with Substance Abuse and Mental Health Services Administration (SAMHSA) and information from other states that implement the YSSF, the MDHHS QIC decided that PIHPs can opt to assign numerical identifiers to the MHSIP in order to identify the respondents. The PIHP was to use the selected field in the data entry forms to inform MDHHS whether they have chosen to assign identifiers. These identifiers are for the PIHPs use only, and are not to be shared with MDHHS. MSHN did not require the use of identifiers for the survey.

Scoring

YSSF – There are six domains included in the survey. Each domain has several individual questions related to the domain topic. Each question in the domain is required to have a response choice of 1 - 5 in order for the domain to be included in the sample. If one question is left blank, the responses of the remaining questions for that domain are excluded from the calculations of that domain. The domains are as follows: quality and appropriateness (satisfaction with service), access to care, family participation in treatment planning, outcomes of care, cultural sensitivity of staff, and social connectedness. There are 5 response choices for each question within the domain, which are assigned a numeric value.

Strongly Agree=5	Disagree=2
Agree=4	Strongly Disagree=1
Neutral=3	

The mean of each individual question is calculated. Those greater than or equal to 3.5 are considered to be “in agreement”. The total number of respondents who are “in agreement” is then divided by the total respondents. The resultant number is then multiplied by 100 to provide a percentage. Those questions that have a “blank” are removed from the sample.

Data Analysis

Each survey was entered into an excel spreadsheet. The HBS program was categorized by numeric codes provided by MDHHS.

The logic for Fiscal Year 2016 was updated to include steps that the state utilizes to calculate the domain percentage scores that were not originally included in the Scoring Protocols provided by the state. MSHN QIC decided to adopt these changes following Fiscal Year 2015; the Scoring Protocols are as follows:

1. Subscale Means

   There are 6 subscales in the survey. To obtain individual subscale scores, each response is assigned the following numerical values:

Strong Agree = 5
Agree = 4
Neutral = 3
Disagree = 2
Strongly Disagree = 1

For each respondent, scores for each item in the subscale are summed, then divided by the total number of items in the subscale. The result is a mean score for each individual respondent that may vary between 1 and 5.

To obtain the program mean, individual means are summed and then divided by the total number of respondents.

Additional logic was obtained from the State which was not originally included in the Scoring Protocols for prior years. The logic clarified that individuals who are missing more than 1/3 of total responses (blanks, or invalid response) are removed completely from the report for calculating subscale scores. Also within the subscales, if an individual is missing 1 or more of the included questions (blanks, or invalid responses) they are removed completely from the subscale scoring for that specific subscale. (The individuals' valid responses are not removed from calculating the response totals to individual questions in Attachment A; even if they were removed from the subscale).

2. Percentage of Respondents in Agreement (by subscale)

   Individual subscale means are computed for each respondent with valid data using the protocol described in section 1.

   Individual mean scores greater than or equal to 3.5 are classified as being "in agreement." The number of respondents "in agreement" is then divided by the total number of respondents with the result multiplied by 100.

The results are analyzed as follows:

PIHP

- By Domain
- By Domain Line Item

CMHSP (Attachment A - YSSF)

- By Domain
- By Domain Line Item

Survey Findings

The Youth Perception of Care Survey

Figure 2 demonstrates the percentage of agreement for each domain. Please refer to the scoring methodology above with questions related to the calculations. Each domain scored above the desired threshold of 80% except the "Perception of Outcomes of Services" and "Perception of Social Functioning". MSHN scored the highest in the "Perception of Cultural Sensitivity", "Perception of Participation in Treatment", "Perception of Access", "Appropriateness", and the "Perception of Social Connectedness" domains. This indicates:

a) The location of services are acceptable to the families who responded to the survey (Q8 - 97%, 366/379)
b) The times that services were available are acceptable to the families who responded to the survey (Q9 - 96%, 365/379)
c) Staff in the MSHN speak to the children in Home-Based services in a way they understand (Q14 - 99%, 359/362)
d) Staff in the MSHN treat the children with respect (Q12 - 99%, 357/362)
e) Staff respect the family's religious or spiritual beliefs (Q13 – 97%, 351/362)
f) Staff are sensitive to each person's cultural or ethnic background (Q15 - 97%, 350/362)
g) Families felt they were able to participate in their child's treatment (Q6 - 99%, 370/377)
h) Families felt they were able to choose their child's services (Q2 - 90%, 341/377)
i) Families felt they were able to choose their child's treatment goals (Q3 - 97%, 367/377).

The percentage of respondents who were in agreement with the survey questions for the domain "Perception of Outcomes of Services" was 65%, which was below the desired threshold of 80%.

The Respondents indicated:

a) Their child was better at handling their daily life (Q16 - 68%, 247/361).
b) Their child was better at coping when things go wrong (Q20 - 59%, 212/361).
c) Families indicated their child gets along better with friends and other people (Q18 - 64%, 230/361).
d) Families indicated their child gets along better with their family (Q17 - 67%, 242/361).
e) Their child was doing better in school and/or work (Q19 – 67%, 242/361).
f) Families indicated their child is able to do things that he/she wants to do (Q22 - 68%, 245/361).
g) Families indicated they were happy with their family life right now (Q21 - 61%, 222/361).

The percentages and respondent numbers for each CMHSP Participant is located in Attachment A.

Figure 2:

* Domain not collected in 2013; added in 2014

Youth Survey	Appropriateness				Perception of Access				Perception of Cultural Sensitivity				Perception of Participation in Treatment			
	2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016	2013	2014	2015	2016
MSHN	90%	92%	90%	**90%**	98%	98%	96%	**97%**	98%	99%	97%	**98%**	95%	95%	96%	**95%**
BABH	64%	80%	93%	**97%**	93%	93%	100%	**98%**	86%	100%	100%	**100%**	46%	93%	100%	**98%**
CEI	86%	93%	86%	**90%**	99%	100%	94%	**97%**	96%	100%	96%	**100%**	55%	91%	94%	**95%**
CMHCM	91%	92%	85%	**91%**	100%	96%	97%	**95%**	98%	100%	98%	**100%**	59%	98%	94%	**99%**
GIHN	97%	100%	92%	**81%**	97%	100%	96%	**95%**	97%	100%	96%	**93%**	81%	100%	92%	**92%**
HBH	100%	79%	83%	**86%**	100%	100%	90%	**93%**	100%	100%	100%	**100%**	0%	93%	100%	**100%**
The Right Door	93%	91%	89%	**88%**	100%	96%	100%	**98%**	100%	100%	100%	**100%**	64%	96%	98%	**98%**
Lifeways	90%	93%	91%	**91%**	96%	97%	96%	**97%**	97%	99%	95%	**95%**	57%	96%	96%	**94%**
MCN	91%	87%	85%	**85%**	100%	93%	95%	**90%**	100%	100%	96%	**97%**	64%	87%	98%	**93%**
NCMH	100%	100%	80%	**80%**	100%	100%	100%	**100%**	60%	100%	95%	**100%**	100%	80%	100%	**89%**
Saginaw	100%	90%	94%	**100%**	100%	100%	83%	**100%**	100%	100%	100%	**100%**	100%	90%	100%	**100%**
Shiawassee	100%	100%	86%	**89%**	100%	100%	93%	**98%**	100%	100%	93%	**95%**	60%	100%	90%	**92%**
TBHS	91%	94%	98%	**98%**	97%	100%	97%	**100%**	91%	97%	99%	**100%**	75%	94%	99%	**96%**

Youth Survey	Perception of Outcome of Services				Perception of Social Connectedness				Perception of Social Functioning			
	2013	2014	2015	2016	2013	2014	2015	2016	*2013	2014	2015	2016
MSHN	63%	65%	60%	**65%**	92%	92%	84%	**88%**	*	69%	61%	**66%**
BABH	77%	53%	67%	**71%**	77%	93%	93%	**84%**	*	60%	71%	**71%**
CEI	86%	73%	71%	**73%**	86%	86%	79%	**88%**	*	73%	73%	**74%**
CMHCM	100%	55%	49%	**65%**	100%	94%	85%	**89%**	*	60%	50%	**65%**
GIHN	59%	79%	59%	**49%**	94%	100%	94%	**87%**	*	82%	61%	**51%**
HBH	100%	57%	51%	**45%**	100%	86%	90%	**68%**	*	50%	53%	**43%**
The Right Door	93%	62%	56%	**45%**	93%	91%	87%	**72%**	*	71%	59%	**46%**
Lifeways	90%	63%	56%	**66%**	90%	97%	83%	**90%**	*	66%	55%	**67%**
MCN	100%	71%	61%	**59%**	100%	93%	81%	**87%**	*	79%	62%	**60%**
NCMH	100%	40%	66%	**63%**	100%	60%	80%	**67%**	*	40%	67%	**63%**
Saginaw	100%	70%	62%	**86%**	100%	90%	100%	**75%**	*	90%	67%	**83%**
Shiawassee	100%	67%	67%	**55%**	100%	67%	70%	**85%**	*	67%	68%	**56%**
TBHS	97%	74%	64%	**80%**	97%	89%	89%	**88%**	*	76%	64%	**80%**

Figure 3 provides a comparison of the percentage of those who responded with "agree-4" or strongly agree-5" for each question within the domain. Please refer to the scoring methodology above with questions related to the calculations.

Figure 3

Youth – Home- Based Services	2013	2014	2015	2016
Perception of Access				
Q8. The location of services was convenient for us.	96%	98%	97%	**97%**
Q9. Services were available at times that were convenient for us.	96%	95%	95%	**96%**
Perception of Participation in Treatment				
Q2. I helped to choose my child's services.	91%	90%	92%	**90%**
Q3. I helped to choose my child's treatment goals.	98%	96%	97%	**97%**
Q6. I participated in my child's treatment.	97%	97%	99%	**98%**
Perception of Cultural Sensitivity				
Q12. Staff treated me with respect.	96%	100%	98%	**99%**
Q13. Staff respected my family's religious/spiritual beliefs.	93%	94%	96%	**97%**
Q14. Staff spoke with me in a way that I understand.	98%	99%	99%	**99%**
Q15. Staff were sensitive to my cultural/ethnic background.	93%	93%	95%	**92%**
Appropriateness				
Q1. Overall, I am satisfied with the services my child received.	92%	93%	95%	**95%**
Q4. The people helping my child stuck with us no matter what.	91%	91%	93%	**92%**
Q5. I felt my child had someone to talk to when she/he was troubled.	88%	90%	92%	**89%**
Q7. The services my child and/or family received were right for us.	91%	88%	92%	**92%**
Q10. My family got the help we wanted for my child.	86%	82%	87%	**87%**
Q11. My family got as much help as we needed for my child.	80%	77%	80%	**83%**
Perception of Outcome of Services				
Q16. My child is better at handling daily life.	65%	69%	64%	**68%**
Q17. My child gets along better with family.	67%	67%	63%	**67%**
Q18. My child gets along better with friends and other people.	65%	63%	61%	**62%**
Q19. My child is doing better in school and/or work.	62%	65%	61%	**65%**
Q20. My child is better able to cope when things go wrong.	58%	59%	56%	**58%**
Q21. I am satisfied with our family life right now.	56%	61%	55%	**61%**
Q22. My child is better able to do things he or she wants to do.	63%	66%	62%	**68%**
Perception of Social Connectedness				
Q23. I know people who will listen and understand me when I need to talk.	88%	88%	85%	**88%**
Q24. I have people that I am comfortable talking with about my child's problems.	88%	91%	88%	**89%**
Q25. In a crisis, I would have the support I need from family or friends.	76%	80%	81%	**82%**
Q26. I have people with whom I can do enjoyable things.	79%	87%	81%	**88%**
Perception of Social Functioning				
Q16. My child is better at handling daily life.	65%	69%	64%	**68%**
Q17. My child gets along better with family.	67%	67%	63%	**67%**
Q18. My child gets along better with friends and other people.	65%	63%	61%	**62%**
Q19. My child is doing better in school and/or work.	62%	65%	61%	**65%**
Q20. My child is better able to cope when things go wrong.	58%	59%	56%	**58%**
Q22. My child is better able to do things he or she wants to do.	63%	66%	62%	**68%**

Recommendations/Improvement Opportunities

The results will be reviewed by the MSHN Quality Improvement Council and the Regional Consumer Advisory Council to determine possible region wide improvement efforts as well as identification of any trends that have occurred from year to year. The results will be compared to national averages as available. The areas of improvement will be targeted towards the domains with the lower average scores (based on the regional average of all scores) and those domains that have shown a decrease from the previous years. Each CMHSP will also review their local results for areas of improvement at the local level. It is also recommended that those with a low number of returned responses review their process and determine if additional action is necessary to increase the response rate. The low number of responses may result in an acceptable threshold based on the standard set or it may result in an unacceptable threshold. The low numbers may also impact the ability for the results to be generalized throughout the population.

Completed by: MSHN

Date: May 2017
Revised: June 2017 & July 2017

MSHN QIC Approved: 06/22/17

Youth Survey		MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	Saginaw	Shiawassee	TBHS
Appropriateness	Domain Average %	90%	97%	90%	91%	81%	86%	88%	91%	85%	80%	100%	89%	98%
1. Overall, I am satisfied with the services my child received.	% Agreement	95%	95%	96%	93%	90%	100%	96%	95%	90%	100%	100%	95%	100%
	# Agree	354	18	53	57	27	7	22	73	26	5	2	21	51
	# Valid Respondents	371	19	55	61	30	7	23	77	29	5	2	22	51
4. The people helping my child stuck with us no matter what.	% Agreement	93%	95%	91%	92%	90%	71%	95%	95%	90%	100%	100%	95%	96%
	# Agree	345	18	48	55	27	5	21	72	26	5	2	21	48
	# Valid Respondents	371	19	53	60	30	7	22	76	29	5	2	22	50
5. I felt my child had someone to talk to when she/he was troubled.	% Agreement	90%	95%	87%	92%	93%	86%	91%	87%	83%	80%	100%	91%	96%
	# Agree	334	18	48	56	26	6	21	67	24	4	2	20	49
	# Valid Respondents	371	19	55	61	28	7	23	77	29	5	2	22	51
7. The services my child and/or family received were right for us.	% Agreement	92%	95%	93%	97%	83%	86%	87%	94%	83%	80%	100%	91%	100%
	# Agree	343	18	51	59	25	6	20	72	24	4	2	20	51
	# Valid Respondents	371	19	55	61	30	7	23	77	29	5	2	22	51

10. My family got the help we wanted for my child.	% Agreement	87%	89%	91%	87%	73%	86%	83%	88%	83%	60%	100%	82%	98%
	# Agree	323	16	50	53	22	6	19	67	24	3	2	18	49
	# Valid Respondents	371	18	55	61	30	7	23	76	29	5	2	22	50
11. My family got as much help as we needed for my child.	% Agreement	84%	89%	80%	85%	63%	86%	74%	87%	79%	60%	100%	77%	98%
	# Agree	310	17	44	52	19	6	17	66	23	3	2	17	49
	# Valid Respondents	371	19	55	61	30	7	23	76	29	5	2	22	50
Perception of Access	**Domain Average %**	**97%**	**98%**	**97%**	**95%**	**95%**	**93%**	**98%**	**97%**	**90%**	**100%**	**100%**	**98%**	**100%**
8. The location of services was convenient for us.	% Agreement	97%	100%	98%	97%	97%	100%	95%	95%	90%	100%	100%	95%	100%
	# Agree	366	19	54	59	29	7	22	73	26	5	2	21	51
	# Valid Respondents	379	19	55	61	30	7	23	77	29	5	2	22	51
9. Services were available at times that were convenient for us.	% Agreement	96%	95%	96%	93%	93%	86%	100%	99%	90%	100%	100%	100%	100%
	# Agree	365	18	53	57	28	6	22	76	26	5	2	22	51
	# Valid Respondents	379	19	55	61	30	7	22	77	29	5	2	22	51
Perception of Cultural Sensitivity	**Domain Average %**	**98%**	**100%**	**100%**	**100%**	**93%**	**100%**	**100%**	**95%**	**97%**	**100%**	**100%**	**95%**	**100%**
12. Staff treated me with respect.	% Agreement	99%	100%	100%	100%	93%	100%	100%	97%	100%	100%	100%	95%	100%
	# Agree	357	19	55	61	28	7	23	75	29	5	2	21	51
	# Valid Respondents	362	19	55	61	30	7	23	77	29	5	2	22	51

13. Staff respected my family's religious/spiritual beliefs.	% Agreement	97%	100%	100%	100%	90%	100%	100%	94%	97%	100%	100%	91%	100%
	# Agree	351	19	55	61	27	7	22	72	28	5	2	20	51
	# Valid Respondents	362	19	55	61	30	7	22	77	29	5	2	22	51
14. Staff spoke with me in a way that I understand.	% Agreement	99%	100%	100%	100%	97%	100%	100%	97%	100%	100%	100%	100%	100%
	# Agree	359	19	55	61	29	7	23	75	29	5	2	22	51
	# Valid Respondents	362	19	55	61	30	7	23	77	29	5	2	22	51
15. Staff were sensitive to my cultural/ethnic back ground.	% Agreement	97%	100%	98%	100%	90%	100%	100%	93.%	92%	100%	100%	95%	100%
	# Agree	350	19	48	60	27	6	22	68	24	5	2	21	49
	# Valid Respondents	362	19	49	60	30	6	22	73	26	5	2	22	49
Perception of Participation in Treatment	**Domain Average %**	**95%**	**98%**	**95%**	**99%**	**92%**	**100%**	**98%**	**94%**	**93%**	**89%**	**100%**	**92%**	**96%**
2. I helped to choose my child's services.	% Agreement	90%	100%	91%	97%	87%	100%	95%	87%	83%	100%	100%	82%	90%
	# Agree	341	19	50	58	26	7	21	66	24	5	2	18	46
	# Valid Respondents	377	19	55	60	30	7	22	76	29	5	2	22	51
3. I helped to choose my child's treatment goals.	% Agreement	97%	95%	96%	98%	93%	100%	100%	97%	97%	100%	100%	95%	98%
	# Agree	367	18	53	60	28	7	23	75	28	5	2	21	50
	# Valid Respondents	377	19	55	61	30	7	23	77	29	5	2	22	51
6. I participated in my child's	% Agreement	99%	100%	99%	100%	97%	100%	100%	97%	100%	68%	100%	100%	100%

treatment.	# Agree	370	19	54	61	28	7	23	75	29	3	2	22	51
	# Valid Respondents	377	19	55	61	30	7	23	75	29	5	2	22	51
Perception of Outcome of Services	**Domain Average %**	**65%**	**71%**	**73%**	**65%**	**49%**	**45%**	**45%**	**66%**	**59%**	**63%**	**86%**	**55%**	**80%**
16. My child is better at handling daily life.	% Agreement	68%	68%	75%	68%	57%	43%	52%	73%	59%	60%	50%	55%	86%
	# Agree	247	13	41	41	16	3	12	56	17	3	1	12	43
	# Valid Respondents	361	19	55	60	28	7	23	77	29	5	2	22	50
17. My child gets along better with family.	% Agreement	67%	68%	75%	68%	52%	57%	41%	75%	52%	60%	50%	55%	84%
	# Agree	242	13	41	41	15	4	9	57	15	3	1	12	42
	# Valid Respondents	361	19	55	60	29	7	22	76	29	5	2	22	50
18. My child gets along better with friends and other people.	% Agreement	64%	58%	69%	66%	46%	43%	39%	66%	64%	40%	100%	50%	82%
	# Agree	230	11	38	39	13	3	9	50	19	2	2	11	40
	# Valid Respondents	361	19	55	59	28	7	23	76	29	5	2	22	49
19. My child is doing better in school and/or work.	% Agreement	67%	79%	67%	64%	55%	43%	61%	66%	68%	80%	100%	59%	78%
	# Agree	242	15	37	37	16	3	14	48	19	4	2	13	39
	# Valid Respondents	361	19	55	58	29	7	23	73	28	5	2	22	50
20. My child is better able to cope when things go wrong.	% Agreement	59%	72%	67%	58%	52%	14%	48%	57%	45%	60%	100%	55%	70%
	# Agree	212	13	37	35	15	1	11	43	13	3	2	12	35

	# Valid Respondents	361	19	55	60	29	7	23	76	29	5	2	22	50
21. I am satisfied with our family life right now.	% Agreement	61%	68%	65%	62%	47%	57%	35%	62%	54%	60%	100%	55%	78%
	# Agree	222	13	36	37	14	4	8	48	15	3	2	12	39
	# Valid Respondents	361	19	55	60	30	7	23	77	28	5	2	22	50
22. My child is better able to do things he or she wants to do.	% Agreement	68%	68%	82%	67%	60%	57%	43%	68%	64%	80%	100%	59%	78%
	# Agree	245	13	45	40	18	4	10	52	18	4	2	13	39
	# Valid Respondents	361	19	55	60	30	7	23	76	28	5	2	22	50
Perception of Social Connectedness	**Domain Average %**	**88%**	**84%**	**88%**	**89%**	**87%**	**68%**	**72%**	**90%**	**87%**	**67%**	**75%**	**85%**	**88%**
23. I know people who will listen and understand me when I need to talk.	% Agreement	89%	89%	87%	92%	90%	71%	96%	88%	90%	80%	100%	86%	88%
	# Agree	334	17	48	56	27	5	22	67	26	4	2	18	44
	# Valid Respondents	375	19	55	61	30	7	23	76	29	5	2	21	50
24. I have people that I am comfortable talking with about my child's problems.	% Agreement	90%	89%	85%	93%	97%	57%	19%	92%	83%	80%	100%	86%	86%
	# Agree	336	17	47	57	29	4	21	71	24	4	2	19	44
	# Valid Respondents	375	19	55	61	30	7	23	77	29	5	2	22	51
25. In a crisis, I would have the support I need from family or friends.	% Agreement	82%	68%	84%	85%	80%	57%	83%	90%	79%	60%	50%	82%	76%
	# Agree	307	13	46	52	24	4	19	69	22	3	1	18	39

	# Valid Respondents	375	19	55	61	30	7	23	77	28	5	2	22	51
26. I have people with whom I can do enjoyable things.	% Agreement	89%	89%	87%	87%	80%	86%	91%	90%	93%	60%	50%	86%	96%
	# Agree	333	17	47	53	24	6	21	69	27	3	1	19	48
	# Valid Respondents	375	19	54	61	30	7	23	77	29	5	2	22	50
Perception of Social Functioning	**Domain Average %**	**66%**	**71%**	**74%**	**65%**	**51%**	**43%**	**46%**	**67%**	**60%**	**63%**	**83%**	**56%**	**80%**
16. My child is better at handling daily life.	% Agreement	68%	68%	75%	68%	57%	43%	52%	73%	59%	60%	50%	55%	86%
	# Agree	247	13	41	41	16	3	12	56	17	3	1	12	43
	# Valid Respondents	361	19	55	60	28	7	23	77	29	5	2	22	50
17. My child gets along better with family.	% Agreement	67%	68%	75%	68%	52%	57%	41%	75%	52%	60%	50%	55%	84%
	# Agree	242	13	41	41	15	4	9	57	15	3	1	12	42
	# Valid Respondents	361	19	55	60	29	7	22	76	29	5	2	22	50
18. My child gets along better with friends and other people.	% Agreement	64%	58%	69%	66%	46%	43%	39%	66%	64%	40%	100%	50%	82%
	# Agree	230	11	38	39	13	3	9	50	19	2	2	11	40
	# Valid Respondents	361	19	55	59	28	7	23	76	29	5	2	22	49
19. My child is doing better in school and/or work.	% Agreement	67%	79%	67%	64%	55%	43%	61%	66%	68%	80%	100%	59%	78%
	# Agree	242	15	37	37	16	3	14	48	19	4	2	13	39

	# Valid Respondents	361	19	55	58	29	7	23	73	28	5	2	22	50
20. My child is better able to cope when things go wrong.	% Agreement	59%	72%	67%	58%	52%	14%	48%	57%	45%	60%	100%	55%	70%
	# Agree	212	13	37	35	15	1	11	43	13	3	2	12	35
	# Valid Respondents	361	19	55	60	29	7	23	76	29	5	2	22	50
22. My child is better able to do things he or she wants to do.	% Agreement	68%	68%	82%	67%	60%	57%	43%	68%	64%	80%	100%	59%	78%
	# Agree	245	13	45	40	18	4	10	52	18	4	2	13	39
	# Valid Respondents	361	19	55	60	30	7	23	76	28	5	2	22	50

IX. Performance Indicators – MMBPIS

Summary Report

Title of Measure: Michigan Mission Based Performance Indicators **MI/DD Adult/Child Data/SUD**

Reporting Period (month/year): FY17Q4

Data Analysis: (threats to validity; statistical testing; reliability of results; statistical significance; need for modification of data collection strategies)

The data is fully valid and reliable. The data is obtained through the state reporting process. This measure allows for exclusions and exceptions. Exceptions are those that chose to have an appointment outside of the 14 days, refuse an appointment that was offered the dates or offered appointments must be documented. Those excluded are those who are dual eligible (i.e. Medicaid/Medicare).

For those CMHSPs who have contracted providers, those numbers are included in the total for that CMHSP. That CMHSP is responsible for insuring that action is taken to improve performance when needed. There may be times when each provider has only one who has not been in compliance, however, when combined, it results in a percentage that is less than the expected threshold. CMHSPs will document action taken to resolve such an issue in the future.

Indicator 1 defines disposition as the decision that was made to refer or not to refer for inpatient psychiatric care. The start time is when the consumer is clinically, medically and physically cleared and available to the PIHP or CMHSP. The stop time is defined as the time when the person who has the authority approves or disapproves the hospitalization. For the purposes of this measure, the clock stops, although other activities to complete the admission may still be occurring.

Indicator 2 defines a new person as an individual who has not received services at that CMHSP/PIHP within the previous 90 days. A professional assessment is defined as a face to face assessment with a professional designed to result in a decision to provide ongoing services from a CMHSP. OBRA consumers are excluded from this count.

Indicator 3 indicates that those consumers who are in respite or medication only services may be excluded if they go beyond the 14-day window; other environmental circumstances also apply. See MDCH full instructions for more specific information regarding those situations.

Indicator 4 does not include dual eligible in the count. Consumers who choose to have an appointment outside of the 7-day window or refuse an appointment within the 7-day window, and those who no

show and do not reschedule. Consumers who choose to not use CMHSP services may be documented as an exception.

Indicator 10 (old 12) indicates those consumers who choose to not use a CMHSP are documented as an exception, and not included in the count.

The above information was taken from the Performance Indicator Codebook. Please refer to the original document for any additional or more specific instructions.

Indicator 1: Percentage of Children/Adults who received a Prescreen within 3 hours of request (standard is 95% or above) – In Figure 1, MSHN demonstrated a 99.59% compliance (482/484) of the **Children** who requested a prescreen received one within three (3) hours. All twelve (12) CMHSPs demonstrated performance above the standard for **Children.** MSHN demonstrated a 99.47% compliance (2421/2434) of the **Adults** who requested a prescreen received one within three (3) hours. All twelve (12) CMHSPs demonstrated performance above the standard for **Adults.**

Indicator 2: Initial Assessment within 14 Days - Children/Adults (standard is 95% or above) – In Figure 1, MSHN demonstrated a 99.16% (3765/3797) compliance for **all population categories** within the indicator. Figure 1 exhibits each CMHSP's performance related to the specific population group. Eleven (11) CMHSPs demonstrated performance above the standard for **MI-Child** and one (1) CMHSP demonstrated performance below the standard. All twelve (12) CMHSPs demonstrated performance above the standard for **MI-Adults**. Eleven (11) CMHSPs demonstrated performance above the standard for **DD-Children** and one (1) CMHSP demonstrated performance below the standard. All twelve (12) CMHSPs demonstrated performance above the standard for **DD-Adults**. SUD providers demonstrated performance above the standard for the **Substance Use Disorder (SUD)** population.

Figure 1

CMHSP	Indicator 1		Indicator 2					
	% Children	% Adults	% MI-C	MI-A %	DD_C %	DD-A %	SA %	Total %
BABH	100.00%	100.00%	98.33%	100.00%	100.00%	100.00%	*	99.55%
CMH for Central MI	100.00%	100.00%	99.29%	99.72%	100.00%	100.00%	*	99.61%
CMHA CEI	98.78%	98.31%	96.37%	97.96%	83.33%	95.24%	*	96.99%
GIHN	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	*	100.00%
HBH	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	*	100.00%
Lifeways	100.00%	99.30%	100.00%	100.00%	100.00%	100.00%	*	100.00%
Montcalm Care Network	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	*	100.00%
Newaygo CMH	100.00%	100.00%	98.21%	100.00%	100.00%	100.00%	*	99.44%

CMHSP	Indicator 1		Indicator 2					
	% Children	% Adults	% MI-C	MI-A %	DD_C %	DD-A %	SA %	Total %
Saginaw CMH	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	*	100.00%
Shiawassee H&W	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	*	100.00%
The Right Door/Ionia	100.00%	100.00%	94.44%	100.00%	100.00%	100.00%	*	98.10%
TBHS	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	*	100.00%
MSHN	**99.59%**	**99.47%**	**98.48%**	**99.65%**	**98.68%**	**98.86%**	**98.95%**	**99.16%**

* Denotes no eligible consumers for that particular indicator for this reporting period (this excludes clients who are listed as exceptions). ** Eligible consumers but were exempt for the indicator during the reporting period.
Key: Green = Above the standard; Tan = Below the standard

Indicator 3: Start of Service within 14 Days (standard is 95% or above) – In Figure 2, MSHN demonstrated a 98.16% (2941/2996) compliance for **all population** categories within the indicator. Figure 2 exhibits each CMHSP's performance related to the specific population group. Nine (9) CMHSPs demonstrated performance above the standard for **MI-Child** with three (3) CMHSP performing below the standard for this indicator. Eleven (11) CMHSPs demonstrated performance above the standard for **MI-Adults** and one (1) CMHSP demonstrated performance below the standard. Nine (9) CMHSPs demonstrated performance above the standard for **DD-Child**, two (2) CMHSP demonstrated performance below the standard, one (1) CMHSPs did not have any eligible individuals to report for the population, and as a region MSHN was below the standard. Eleven (11) CMHSPs demonstrated performance above the standard for **DD-Adult** and one (1) CMHSP performing below the standard. All applicable SUD providers demonstrated performance above the standard for the **Substance Use Disorder (SUD)** population.

Indicator 4a: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (standard is 95% or above) – In Figure 2, MSHN demonstrated a 100% (82/82) compliance for **Children** with a diagnosis of mental illness. All twelve (12) CMHSPs demonstrated performance above the standard. MSHN exhibited a 96.55% (504/522) compliance for **Adults** who have a diagnosis of mental illness. Eleven (11) CMHSPs demonstrated performance above the standard for this population with one (1) CMHSPs performing below standard for this indicator.

Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (standard is 95% or above) – MSHN demonstrated a 98.69% (226/229) compliance for individuals who were seen for follow-up care within 7 days of discharge from a detox unit. Performance was above the standard for the **Substance Use Disorder (SUD)** population for this indicator.

Indicator 10: Re-admission to Psychiatric Unit within 30 Days (standard is 15% or less) – In Figure 2, MSHN demonstrated a 12.20% (15/123) compliance for **children** who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. Eight (8) CMHSPs demonstrated performance above

the standard and four (4) CMHSPs demonstrated performance below the standard. MSHN demonstrated a 10.34% (86/832) compliance for **adults** who have a diagnosis of mental illness. Ten (10) CMHSPs demonstrated performance above the standard and two (2) CMHSPs demonstrated performance below the standard.

Figure 2

	Indicator 3						Indicator 4a		4b	Indicator 10	
	% MI-C	% MI-A	% DD-C	% DD-A	% SA	Total	% Children	% Adults	% All	% Children	% Adults
BABH	96.00%	96.12%	33.33%	100.00%	*	95.16%	100.00%	97.18%	*	15.79%	6.73%
CMH for Central MI	98.13%	96.80%	100.00%	100.00%	*	97.31%	100.00%	96.67%	*	0.00%	9.72%
CMHA CEI	91.67%	95.68%	100.00%	100.00%	*	94.39%	100.00%	90.32%	*	10.00%	10.43%
GIHN	97.44%	100.00%	100.00%	100.00%	*	99.10%	100.00%	100.00%	*	0.00%	18.18%
HBH	100.00%	100.00%	100.00%	100.00%	*	100.00%	100.00%	100.00%	*	16.67%	0.00%
Lifeways	95.83%	97.37%	100.00%	100.00%	*	97.28%	100.00%	97.52%	*	13.33%	12.87%
Montcalm Care Network	100.00%	100.00%	100.00%	100.00%	*	100.00%	100.00%	100.00%	*	33.33%	7.41%
Newaygo CMH	100.00%	97.47%	100.00%	100.00%	*	98.31%	100.00%	100.00%	*	0.00%	0.00%
Saginaw CMH	100.00%	99.30%	93.33%	93.75%	*	98.58%	100.00%	97.44%	*	14.29%	9.17%
Shiawassee CMH	90.00%	95.65%	100.00%	100.00%	*	94.59%	100.00%	100.00%	*	0.00%	10.53%
The Right Door	100.00%	94.74%	*	100.00%	*	96.74%	100.00%	100.00%	*	25.00%	18.18%
TBHS	93.75%	100.00%	100.00%	100.00%	*	98.73%	100.00%	100.00%	*	0.00%	10.00%
MSHN	96.72%	97.46%	94.74%	98.55%	99.91%	98.16%	100.00%	96.55%	98.69 %	12.20%	10.34%

Above Standard | Below Standard

* Denotes no eligible consumers for the indicator during the reporting period (this excludes clients who are listed as exceptions).

** Eligible consumers but were exempt for the indicator during the reporting period.

Figure 3 shows a comparison of the performance indicator percentages starting in FY15 Quarter 4 to current. MSHN was within the established standards set by the state for each of the performance indicators during the current reporting period. MSHN will continue to monitor individual CMHSP performance requiring improvement plans as needed to ensure performance remains above the standard across the PIHP, and that interventions are effective in addressing the deficiencies.

Figure 3a

MMBPIS		FY16Q2	FY16Q3	FY16Q4	FY17Q1	FY17Q2	FY17Q3	FY17Q4
Indicator 1a & 1b: Pre-screen within 3 hours of request	**Child**	99.60%	99.02%	99.77%	99.10%	99.17%	99.42%	99.59%
	Adult	98.65%	98.97%	98.70%	98.72%	98.89%	99.31%	99.47%
Indicator 2: % of Persons Receiving an Initial Assessment within 14 calendar days of First Request	**MI-Child**	98.79%	98.72%	99.41%	98.19%	98.90%	98.51%	98.48%
	MI-Adult	99.45%	99.20%	99.18%	98.81%	98.78%	99.26%	99.65%
	DD-Child	98.44%	100.00%	96.92%	98.67%	100.00%	97.30%	98.68%
	DD-Adult	100.00%	98.82%	97.53%	100.00%	100.00%	100.00%	98.86%
	SA	96.37%	98.96%	99.55%	98.41%	98.47%	98.39%	98.95%
	Total	**99.20%**	**99.02%**	**99.26%**	**98.55%**	**98.78%**	**98.82%**	**99.16%**
Indicator 3: % of Persons Who Started Service within 14 days of Assessment	**MI-Child**	96.98%	96.83%	97.45%	97.87%	97.23%	96.98%	96.72%
	MI-Adult	97.96%	97.55%	97.65%	97.50%	97.31%	98.25%	97.46%
	DD-Child	95.74%	96.36%	100.00%	100.00%	96.97%	100.00%	94.74%
	DD-Adult	98.11%	96.36%	100.00%	93.94%	97.37%	98.48%	98.55%
	SA	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.91%
	Total	**97.44%**	**98.32%**	**98.64%**	**98.46%**	**98.18%**	**98.61%**	**98.16%**
Indicator 4a, and Indicator 4b: Persons seen within 7 days of Inpatient Discharge and Substance Abuse Detox	**Child**	100.00%	99.14%	100.00%	98.13%	98.52%	99.22%	100.00%
	Adult	98.32%	97.03%	96.97%	97.11%	98.26%	96.97%	96.55%
	SA	100.00%	100.00%	99.57%	100.00%	97.60%	97.51%	98.69%

		FY15Q4	FY16Q1	FY16Q2	FY16Q3	FY16Q4	FY17Q1	FY17Q2
Indicator 10: % of Discharges Readmitted to Inpatient Care within 30 days of Discharge	**Child**	11.90%	8.72%	9.43%	8.11%	8.97%	11.88%	12.20%
	Adult	8.26%	10.58%	11.88%	9.85%	7.61%	11.10%	10.34%
		Above Standard	Below Standard					

Figures 4 through 7 exhibit the percentage of exceptions that were reported for the total population. The variance might indicate a difference in practice or definition.

Figure 4: Indicator 2 - Exception Report

Indicator 2	FY16Q2	FY16Q3	FY16Q4	FY17Q1	FY17Q2	FY17Q3	FY17Q4
BABH	17.27%	12.42%	20.13%	13.33%	17.95%	16.26%	**13.73%**
CMHCM	8.51%	7.55%	4.47%	2.79%	3.69%	6.07%	**4.11%**
CEI	11.22%	6.96%	6.29%	7.98%	8.26%	6.90%	**10.58%**
GIHN	10.20%	4.10%	4.03%	1.59%	28.40%	15.50%	**6.06%**
HBH	3.41%	20.25%	15.09%	19.72%	29.17%	18.06%	**12.28%**
Lifeways	12.24%	10.49%	36.59%	12.32%	11.76%	6.44%	**6.10%**
Montcalm Care Network	10.59%	8.12%	5.06%	1.68%	3.47%	0.93%	**1.87%**
Newaygo	1.55%	1.48%	2.06%	2.91%	4.62%	10.31%	**3.76%**
Saginaw	4.95%	4.47%	3.39%	4.53%	1.14%	1.81%	**1.10%**
Shiawassee	2.63%	2.90%	1.95%	3.45%	2.13%	12.96%	**4.65%**
The Right Door/Ionia	0.00%	6.67%	6.25%	23.74%	29.94%	37.68%	**25.00%**
TBHS	12.84%	20.00%	9.09%	22.39%	14.39%	23.21%	**23.76%**
MSHN	**8.39%**	**7.55%**	**7.10%**	**7.33%**	**9.74%**	**9.47%**	**7.76%**

Figure 4: The following are exceptions for Indicator 2: Consumers who request an appointment outside the 14 calendar day period or refuse an appointment offered that would have occurred within the 14 calendar day period, or do not show for an appointment or reschedule it. Dates offered or refused must be documented.

Figure 5: Indicator 3 - Exception Report

Indicator 3	FY16Q2	FY16Q3	FY16Q4	FY17Q1	FY17Q2	FY17Q3	FY17Q4
BABH	24.00%	22.50%	22.45%	16.67%	17.88%	20.28%	**27.06%**
CMHCM	22.09%	23.77%	19.35%	14.18%	21.49%	17.86%	**19.65%**
CEI	35.37%	26.87%	27.24%	27.79%	28.92%	23.65%	**22.76%**
GIHN	13.39%	12.50%	9.73%	9.78%	28.67%	11.76%	**10.48%**

Figure 5: The following are exceptions for Indicator 3: Consumers who request an appointment outside the 14 calendar day period or refuse an appointment offered that would have occurred within the 14 calendar day period, or do not show for an appointment or reschedule it. Dates offered or refused must be documented.

OR

Consumers for whom the intent of service was medication only or respite only and the date of service exceeded the 14 calendar days. May also exclude environmental modifications where the completion of a project exceeds 14 calendar

HBH	19.05%	1.85%	28.57%	18.57%	27.14%	23.19%	**20.75%**
Lifeways	17.95%	18.70%	45.05%	14.15%	15.31%	19.34%	**23.28%**
Montcalm Care Network	21.37%	20.52%	19.33%	21.05%	22.27%	17.99%	**20.00%**
Newaygo	16.36%	21.31%	20.39%	17.65%	22.09%	25.32%	**18.06%**
Saginaw	20.14%	10.29%	22.54%	23.55%	27.73%	26.89%	**25.61%**
Shiawassee	21.08%	22.22%	22.31%	16.67%	5.00%	11.86%	**7.50%**
The Right Door/Ionia	10.81%	5.71%	8.00%	23.97%	23.26%	29.85%	**14.02%**
TBHS	6.98%	7.77%	8.96%	3.28%	3.92%	4.30%	**1.25%**
MSHN	**21.29%**	**20.33%**	**21.77%**	**18.21%**	**22.01%**	**20.58%**	**20.53%**

Figure 6a: Indicator 4a – Exception Report

Indicator 4a	FY16Q2	FY16Q3	FY16Q4	FY17Q1	FY17Q2	FY17Q3	FY17Q4
BABH	7.55%	10.34%	10.84%	32.38%	35.83%	28.24%	**31.40%**
CMHCM	14.44%	18.89%	10.59%	10.00%	38.08%	22.22%	**17.28%**
CEI	46.48%	52.26%	51.53%	44.71%	38.08%	40.78%	**52.04%**
GIHN	0.00%	14.29%	17.39%	57.50%	17.86%	30.00%	**26.67%**
HBH	14.29%	5.56%	35.29%	37.04%	36.36%	54.17%	**43.75%**
Lifeways	18.75%	22.22%	15.38%	24.03%	35.55%	29.70%	**41.38%**
Montcalm Care Network	28.10%	21.74%	19.44%	18.75%	17.78%	12.50%	**40.00%**
Newaygo	18.18%	12.50%	31.03%	27.27%	14.29%	45.45%	**23.81%**
Saginaw	25.00%	11.11%	33.33%	20.51%	26.95%	18.30%	**28.46%**
Shiawassee	25.64%	31.34%	25.00%	30.00%	0.00%	21.74%	**15.00%**
The Right Door/Ionia	0.00%	27.27%	19.05%	10.00%	41.94%	28.57%	**7.69%**
TBHS	37.50%	37.93%	41.67%	51.52%	23.53%	46.15%	**40.00%**
MSHN	**25.37%**	**27.26%**	**28.53%**	**30.64%**	**33.62%**	**29.81%**	**36.41%**

Figure 6a: The following are exceptions for Indicator 4a: Consumers who request an appointment outside the seven-day period or refuse an appointment offered that would have occurred within the seven calendar day period, or do not show for an appointment or reschedule it. Must document dates of refusal or dates offered.

OR

Consumers who choose not to use CMHSP/PIHP services. For the purposes of this indicator, Providers who provide substance abuse services only, are currently not considered to be a CMHSP/PIHP service. Therefore,

Figure 6b: Indicator 4b - Exception Report

Figure 6b: The following are exceptions for 4b: Consumers who request an appointment outside the seven-day period or refuse an appointment offered that would have occurred within the seven calendar day period, or do not show for an appointment or reschedule it. Must document dates of refusal or dates offered.

OR

Indicator 4b	FY16Q2	FY16Q3	FY16Q4	FY17Q1	FY17Q2	FY17Q3	FY17Q4
MSHN	44.34%	0.00%	0.00%	0.00%	0.00%	1.63%	**0.80%**

Figure 7: Indicator 10 - Exception Report

Indicator 10	FY16Q2	FY16Q3	FY16Q4	FY17Q1	FY17Q2	FY17Q3	FY17Q4
BABH	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
CMHCM	0.00%	0.00%	0.00%	0.00%	0.83%	0.00%	**0.00%**
CEI	4.93%	0.00%	3.57%	3.53%	0.83%	2.15%	**2.94%**
GIHN	0.00%	4.76%	4.17%	50.00%	39.29%	17.24%	**13.33%**
HBH	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Lifeways	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Montcalm Care Network	0.00%	0.00%	0.00%	2.94%	2.22%	0.00%	**3.23%**
Newaygo	0.00%	0.00%	3.45%	0.00%	14.29%	36.36%	**14.29%**
Saginaw	0.00%	11.11%	33.33%	0.00%	2.13%	0.00%	**0.00%**
Shiawassee	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
The Right Door/Ionia	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
TBHS	0.00%	0.00%	0.00%	0.00%	0.00%	7.89%	**4.00%**
MSHN	**0.97%**	**1.05%**	**1.69%**	**3.33%**	**1.78%**	**1.68%**	**1.64%**

Figure 7: The following are exceptions for Indicator 10: Discharges who choose not to use CMHSP/PIHP Services.

The following table identifies the individual CMHSP's that are required to submit a plan of correction for the current quarter, the plans of correction that are in place from the previous 3 quarters and the performance indicators that each CMHSP are identified as having a best practice for achieving the established standard.

	Current Quarter's Performance Below Standard Requiring Action	Intervention plan in place and being monitored to reach full impact			Regional Best Practice (≥ 3 data points)
		FY17 Q1	FY17 Q2	FY17 Q3	
BABH	3c, 10a	2a	3c	3a,4a2,	1
CMHCM	NA	NA	NA	NA	1, 2, 3, 4, 10
CEI	2c, 3a, 4a2	3d, 4a1	4a1, 10a	2c,3d	1
GIHN	10b	10a	1a, 3a	10a,10b	2, 4
HBH	10a	3b, 4a1, 10a	NA	10a	1, 2
Lifeways	NA	4a2, 10b	NA	NA	1, 2, 3
MCN	10a	3b	3d, 4a1	NA	1, 2
Newaygo	NA	NA	NA	NA	1, 2, 3, 4, 10
Saginaw	3c, 3d	NA	NA	10a	1, 2, 4
Shiawassee	3a	NA	NA	3a,4a2,10b	1, 2
The Right Door	2a, 3b, 10a, 10b	1a, 2a, 2c, 3a, 4a2	2a, 3d,	10a	NA
TBHS	3a	NA	NA	NA	1, 2, 4, 10

Note: The plans of correction (identified in the "interventions" column) are only in effect for the previous 3 quarters. If an indicator is noted as out of compliance and a plan has been in place for 3 or more quarters, then the CMH is required to submit a new plan of correction.

Improvement Strategies:

Those indicators that are listed under "Best Practice" are those that have met the standard for 95% for all populations for 3 or more quarters. Since corrective action plans often are in place for up to 4 quarters before they reach full impact, it may not be unusual for someone to have a corrective action plan in place and still meet the criteria for "Best Practice". For those who have indicators listed under the "Best Practice" column, it may be useful to share what is being done with others.

All CMHSPs who demonstrate performance below the standard for each population group will submit a corrective action plan to MSHN within 30 days of the presentation of this report to the Quality Improvement Council. The corrective action plan should be completed using the standard template and include a specific date of impact, and clearly identify the indicator in which the action is addressing.

CMHSPs should review data prior to submission to ensure the appropriate data elements are submitted according to the format as indicated in the instructions. The exception data should be identified based on the definitions provided in the instruction document. This information will be reviewed during the Quality Improvement Council meeting to ensure there is a clear understanding of the expectations.

Completed by: MSHN **Date:** January 2018

X. Provider Network Monitoring Review

Monitoring and Auditing

Mid-State Health Network Internal Audits

The 2017 (calendar year) Mid-State Health Network monitoring and oversight review of the Community Mental Health Service Provider's (CMHSP) and the Substance Use Disorder Service Providers (SUDSP) included a review of the Delegated Managed Care Functions as well as the Program Specific Requirements to ensure compliance with federal and state requirements.

CMHSP Delegated Managed Care Reviews

CMHSP Delegated Managed Care Functions

This review included sixteen (16) standards and one hundred forty-four (144) elements. The full review consisted of an on-site visit to the CMHSP Participant to conduct consumer chart reviews, review and validate process requirements, review of new standards since the last audit, analysis of performance and encounter data, interviews of staff, and monitoring of the FY16 desk-audit corrective action plans as applicable.

Compliance percent is calculated as the number of standards correct over total number of standards (based on the number of participating CMHSPs).

Performance Variables for Consideration

- Changes to monitoring tool related to scope of review for specific standards

Status:

- 12 of 12 CMHSP full site visits completed by MSHN staff
- 10 of 12 Corrective Action Plan's received from the CMHSP's
- 8 of 12 Corrective Action Plan's reviewed and approved by MSHN staff

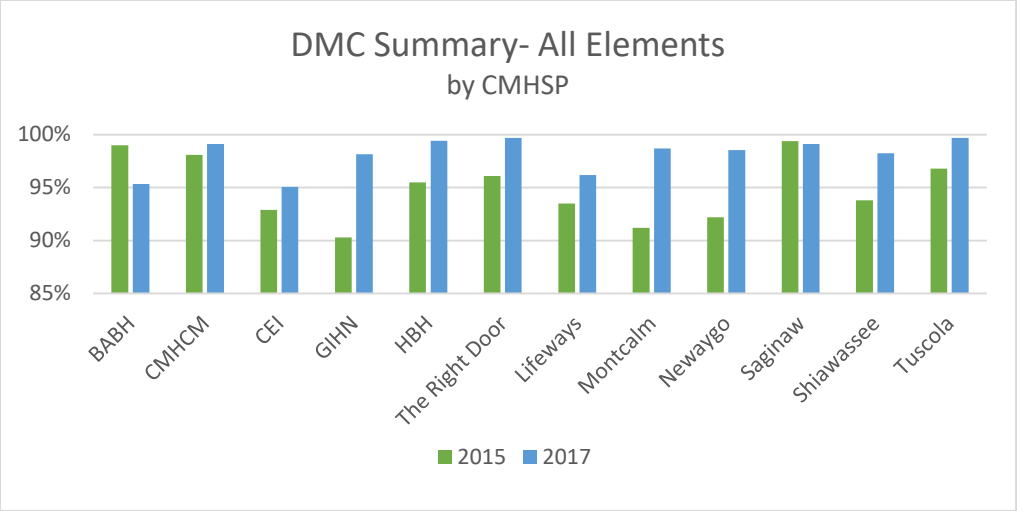
Delegated Managed Care Functions	2015 Results	2017 Results	Performance Comparison
Information and Customer Service	89.6%	97.9%	8.3%
Enrollee Rights & Protections	99.1%	100.0%	0.9%
24/7/365 Access[2]	94.8%	98.5%	3.7%
CMHSP Provider Network (sub-contract providers)	95.5%	97.8%	2.3%
Service Authorization & UM	90.8%	100.0%	9.2%
Grievance & Appeals	95.8%	97.7%	1.9%
Person Centered Planning & Documentation	97.5%	98%	0.5%
Advance Directives[3]	95.8%	N/A	N/A
Coordination of Care/Integration [4]	97.9%	97.5%	-0.4%
Behavior Treatment Plan Review Committee	88.3%	98.5%	10.2%
Consumer Involvement	98.6%	100.0%	1.4%
Provider/Staff Credentialing	90.3%	95.4%	5.1%
Quality & Compliance	98.1%	99.1%	1.0%
Ensuring Health & Welfare/Olmstead	97.7%	99.1%	1.4%
Information Technology	100.0%	100.0%	0.0%
Trauma Informed Care[5]	N/A	96.8%	N/A

[2] Access Policy revisions resulted in new standards in 2016

[3] Advance Directives standards were combined with Customer Services standards in 2017

[4] Coordination of Care/Integration of Behavioral & Physical Health Services section was updated in 2017 to include three (3) additional standards focusing on coordination of follow-up after hospitalization, follow-up of shared members with the MHP through ICDP, CC360, and/or MIHIN. As a result of the additional standards, a slight decrease was noted from 2015 to 2017

[5] New Trauma Informed Care resulted in new standards in 2017

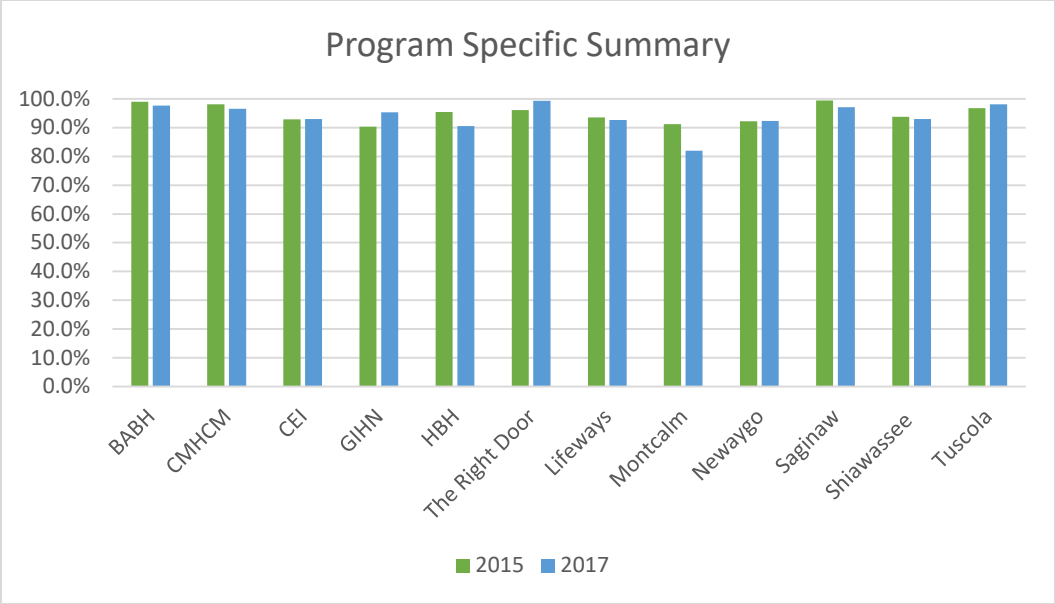


CMHSP Program Specific Site Review

This review included ten (10) standards and a total of eight-five (85) elements. The focus of this section was to ensure compliance with the Michigan Department of Health & Human Services (MDHHS) Program Specific Requirements.

Compliance percent is calculated as the number of standards correct over total number of standards (based on the number of participating CMHSPs).

Program Specific	2015 Results	2017 Results	Performance Comparison
Jail Diversion	93.8%	95.3%	1.5%
Assertive Community Treatment (ACT)	98.1%	100%	1.9%
Self Determination	95.4%	97.3%	1.9%
Peer Delivered and Operated Services (Drop-In)	100.0%	91.7%	-8.3%
Home Based Services	95.0%	98.3%	3.3%
Clubhouse Psycho-Social Rehabilitation	100.0%	96.4%	-3.6%
Crisis Residential Services	93.1%	85.6%	-7.5%
Targeted Case Management	91.7%	97.5%	5.8%
Habilitation Supports Waivers	95.0%	96.7%	1.7%
Autism Benefit/Applied Behavioral Analysis	86.7%	87.7%	0.0%



Ensuring excellent quality and identifying areas for opportunity is completed in partnership with the CMHSPs. The number of charts reviewed during each onsite visit is generally between five (5) and eight (8). Administrators, supervisors, and direct care team members are available for guidance, interviews, and discussion during the 2-day onsite reviews. However, this does not include the time spent preparing for an extensive quality assurance and performance improvement review. Each of MSHN's CMHSP partners did an excellent job assisting in the process.

CMSHP Training

Regional trainings were conducted during this past year that included topics such as:

- Autism
- Home and Community Based Waiver Rules

CMHSP Noteworthy Strengths

The CMHSPs are focusing on Better Health/Integrated Treatment. The Integrated Health Care chart review consistently demonstrated diligent efforts to improve overall health outcomes. Together, the CMHSPs are demonstrating dedication to ensuring overall better health for our consumers. Examples include onsite wellness programs, community-based workout/exercise opportunities, and clinical interventions including trauma-based yoga.

Community Mental Health for Central Michigan developed an enhanced integrated healthcare program and is generating data that evidences overall improvements to focus areas including diabetes. Leadership has provided ongoing support to their teams to ensure the services are provided, data is collected, and outcomes are shared. Information sharing has, per interviews with key staff, been instrumental in ensuring accurate data. Both consumers and those providing direct services can see accomplishments throughout treatment/engagement.

The CMHSPs are consistently leading community efforts to enhance trauma-informed interactions with a variety of stakeholders including local police departments, Department of Health & Human Services, legal systems, and schools. It is evident that there is a focus on evidence-based practices such as *No Harm Done* which strives to protect children from unintended consequences after traumatic events. Several examples of excellent trauma-informed practices are present throughout the region.
Saginaw CMHSP, for example, helped their community's healing process after a tragic event. The Saginaw team worked with their local law enforcement, training and educating, and has since built a strong partnership in which law enforcement even reach out to Saginaw CMHSP for assistance when mental health is a factor.

Another example of regional excellence includes supporting team members and ensuring secondary/vicarious trauma impacts are prevented and/or treated appropriately. Upon evaluation of internal surveys in which staff were asked questions regarding supports, training, and competence, many CMHSPs have implemented internal supportive practices such as education on the impact of treating trauma survivors, open-door supervision, and company morale activities.

Overall, the CMHSPs have implemented practices to ensure that members have 24/7/365 access to the SUDSP screening and referral. Consistently, the CMHSPs share recommendations, strengths, and concerns regarding collaboration of care with the SUDSPs. This is demonstration of a growing partnership with a shared goal of ensuring consumers receive excellent care for co-occurring disorders.

CMHSP Opportunities

An enhanced focus for 2018 includes efforts to ensure quality care services, based on data-driven outcomes, are consistently provided/maintained throughout the region. Enhancement opportunities are discussed with the CMHSPs and other stakeholders so the reviews accurately & effectively capture the dedication to overall improved health through cost-effective, quality care services. The 2017 review analysis indicates growing opportunities including:

- Enhancing Person-Centered Planning Documentation and/or Delivery - Electronic Medical Records (EMR) are an excellent way of ensuring consumers are protected by indication that they were notified of their rights, benefits, etc. However, EMRs also unintentionally create an avenue for limited narrative and human error (checking the wrong box). The amended Person-Centered Planning Policy includes guidelines for improving both documentation and service enhancement.

- Continue Enhancing Coordination of Care Efforts with SUDSPs - the CMHSP Participants and the SUDSPs should continue enhancing their relationships to ensure that every individual served receives medically necessary services that are unique to the individual. Methods of continued enhancement may include:
    - Increasing number of signed Coordination of Care Agreements with SUDSPs;
    - Education and information on services/programs within both the CMHSP and SUDSP network;
    - Developing mutual clinical goals that will require efforts of all, such as reducing the number of opioid-related deaths, increasing dual-enrollments, enhancing discharge planning and referrals.

SUDSP Delegated Managed Care Reviews

SUDSP Delegated Managed Care Functions

This review included ten (10) standards and a total of one hundred fifty-two (152) elements. The full review consisted of an on-site visit to the SUDSP to conduct consumer chart reviews, review and validate process requirements, review new standards added since previous audit, analyze performance and encounter data, interview staff, and monitor FY16 desk-audit corrective action plans as applicable.

SUDSP Treatment Quality Assurance

MSHN completed 19 full SUDSP treatment provider reviews and 18 interim reviews in 2017. Note, many providers may have more than one licensed site. The number of charts reviewed during each onsite visit is a 5% sample, with a minimum of two (2) and maximum of eight (8) for each licensed site.

Prior to 2017, reviews were conducted at each licensed site. As a result, data includes multiple site reviews for one provider. Therefore, a comparison of 2015 and 2017 data would not be an accurate reflection. MSHN will utilize 2017 reviews as a baseline for comparison in upcoming years.

Compliance percent is calculated as the number of standards correct over total number of standards (based on the number of participating SUDSPs (19 full reviews completed at time of report).

Delegated Managed Care Functions	# of Standards in each Section	2017 Results
Access and Eligibility	6	68.5%
Information and Customer Service	21	83.7%
Enrollee Rights and Protections	15	86.3%
Grievance and Appeals	18	56.6%
Quality and Compliance	12	68.1%
Authorizations/UM	4	66.7%
Individualized Treatment & Recovery Planning & Documentation	12	74.8%
Policy and Procedure Review	37	80.4%
Coordination of Care	11	55.1%
Provider Staff Credentialing	16	59.9%

SUDSP Treatment Training

Regional trainings were conducted during the quarterly SUDSP meetings and other venues and included topics such as:

- Staff Credentialing and Recredentialing
- Recovery Oriented Systems of Care
- Grievance and Appeals
- Trauma Informed Care
- Preventing Opiate Overdose
- The Relationship of Social Determinants of Health and the Effect of Trauma and Related Responses to Care
- Women's Specialty Services
- Sub-Regional Coordination of Care Planning between Recovery Residence and Outpatient Providers
- Acupuncture Certification (NADA)
- Promoted statewide training opportunities to provider network such as ASAM Level of Care

SUDSP Treatment Noteworthy Strengths

The SUDSP network is expanding the internal service array to include programming that meets the needs of individual consumers based on medical necessity. Expansion efforts include implementing group/individual therapeutic services, hiring Peer Recovery Coaches, developing effective case management practices, and ensuring team members receive training in evidence-based programming that meets the needs of the population.

MSHN providers have implemented practices to meet opioid-abuse prevention and treatment goals. This is evidenced by enhanced service arrays offered by Medication-Assisted Treatment Providers, implementation and oversite of neo-natal exposure programming, increased number of consumers dually enrolled in treatment & recovery programs to ensure all needs are effectively addressed.

MSHN expanded services by securing SUDSP Recovery Residence contracts with a variety of providers who help secure safe environments for persons in treatment and recovery from the disease of addiction. Collaboration with housing providers has begun and is in a growing process that includes understanding what information can and should be shared to ensure coordination of care.

SUDSP Treatment Opportunities

- Increase data-driven outcome reporting
- Enhance use of evidence-based programming
- Improve Continuum of Care Efforts
- Develop practices that support coordination of care efforts

SUDSP Prevention Quality Assurance Reviews

This review included five (5) standards and a total of thirty-four (34) elements. The desk review consisted of policies and procedures, performance, reporting, and administration. MSHN has completed 35 of 35 desk reviews as of December 30, 2017.

SUDSP Prevention Programming	# of Standards in each Section	2017 Results
General Standards	10	88.7%
Evaluation & Performance Improvement	2	83.6%
Designated Youth Tobacco Use Representative	8	96.5%

Reporting	4	96.8%
Administration	10	81.2%

In order to effectively ensure quality, Mid-State Health Network Prevention Specialists complete an onsite program observation review to assess provider for excellent professional behavior, facilitation skills, community resource knowledge, and general evidence-based program delivery. As of November 30, 2017, 35 onsite reviews were completed.

The Michigan Prevention Data System is used to ensure compliance with respect to utilization and fidelity. Prevention Specialists conduct monthly reviews to ensure timeliness of data input. An overall outcomes report will be included in the January 2018 quarterly report as the FY17 Provider Outcome Reports are due in December 2017.

SUDSP Prevention Training

Regional trainings are conducted during the quarterly SUDSP meetings and other venues and included topics such as:

- Motivational Interviewing
- Trauma Informed Practices
- Analyzing MiPHY
- Coalition Improvement
- Engaging Youth
- State of Marijuana

SUDSP Prevention Noteworthy Strengths

- Providers consistently demonstrate expert content knowledge of community resources and referral systems
- Providers consistently demonstrate excellent professional behaviors including preparation and timeliness
- Facilitation styles are appropriate for the intended audience with consideration of demographic & cultural factors
- Increased focus on opiate abuse prevention as demonstrated through newly established partnerships with regional health care providers that focus on:
    - Opioid Prescription Policies
    - Prevention of Abuse Trainings
- Increased partnerships with schools as indicated by an increased number of schools allowing prevention programming during the school year and participation in the Michigan Profiles Healthy Youth (MiPHY) survey

SUDSP Prevention Opportunities

- Enhance regional Prevention Coalition relationships
- Increase MiPHY Participation
- Increase delivery of evidence-based programs that improve academic performance and health
- Implement monthly MPDS accuracy checks

MSHN Quality Assurance & Performance Improvement (QAPI)Next Steps

The scope of the 2018 Delegated Managed Care Site Review work plan includes:

- Full reviews for SUDSPs who received a full review in 2016;
- Corrective Action Plan Compliance follow-up of full reviews completed in 2017 for both CMHSPs and SUDSP;
- New Standards for CMHSPs – Home and Community Based Service requirements for onboarding new providers and ensuring existing providers are coming into compliance; Encounter/Data submission;
- New Standards for SUDSPs – ASAM Level of Care verification; Financial Audit; Medication-Assisted Treatment Policy Changes; MPDS Compliance Verification;
- Develop a SUDSP Advisory Group to inform data analysis and performance improvement strategies;
- Improving the review process by enhancing the quality of services evaluation to data-driven outcomes;
- Develop and implement process for quarterly compliance and quality reports that include all relevant departments such as prevention, utilization management, and recipient rights.

XI. External Quality Reviews – MDHHS and HSAG

Monitoring and Auditing

Mid-State Health Network External Audits

MDHHS Habilitation Supports Waiver Site Visit Report: February 27th – March 7th

The Michigan Department of Health and Human Services (MDHHS) conducted a follow up review on-site for our region from February 27, 2017 through March 7, 2017. The purpose was to review the status of the required corrective action plans from the review completed during Fiscal Year 2016 for the Habilitation Supports Waiver (HSW), the Waiver for Children with Serious Emotional Disturbance (SEDW), the Children's Waiver Program (CWP) and the Wraparound Fidelity review.

Note: The SEDW, CWP and Wraparound Fidelity review is the responsibility of the CMHSP and therefore the follow up review was completed at the CMHSP's, not at MSHN.

The 2017 site review included the review of beneficiary files, staff records and home visits to ensure the required plans of correction were implemented and effective in correcting the identified issues.

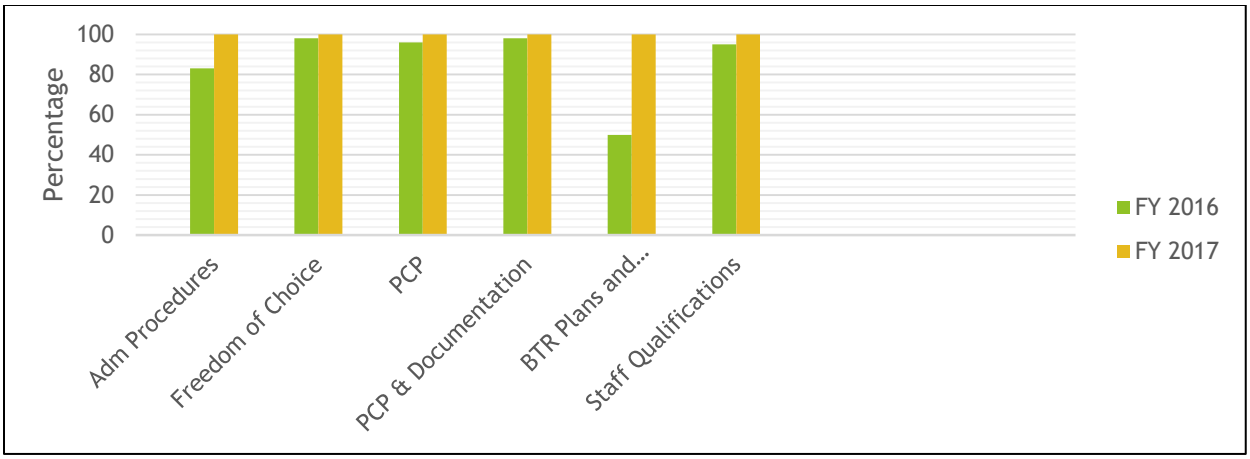
Summary of the findings:

A. Administrative Procedures (1 element): 100%
B. Freedom of Choice (2 Elements): 100%
C. Implementation of Person Centered Planning (6 Elements): 100%
D. Plan of Service and Documentation Requirements (1 Elements): 100%
E. Behavior Treatment Plans and Review Committees (1 Elements): 100%
F. Staff Qualifications (4 Elements): 100%
G. Home Visits/Training/Interviews (1 home): 100%

Next Steps:

MSHN received a status of full compliance with all required plans of correction for FY2017. No further action is necessary at this time regarding the plans of correction. During the FY2016 site review, MSHN was found to have repeat citations (from the FY2014 review) for eleven standards. MSHN will be monitoring the repeat citations to ensure full compliance during the next review. A full review by MDHHS of all standards will be completed for MSHN during FY2018.

Comparison of Results Full Review for FY2016 and Follow Up Review for FY2017:



MDHHS Substance Use Site Review Report: February 27th

The Michigan Department of Health and Human Services (MDHHS) completed a follow up review at Mid-State Health Network (MSHN) on February 27, 2017 to determine compliance with the required corrective action plans that resulted from the full review completed during Fiscal Year 2016 for Substance Use Disorder Services.

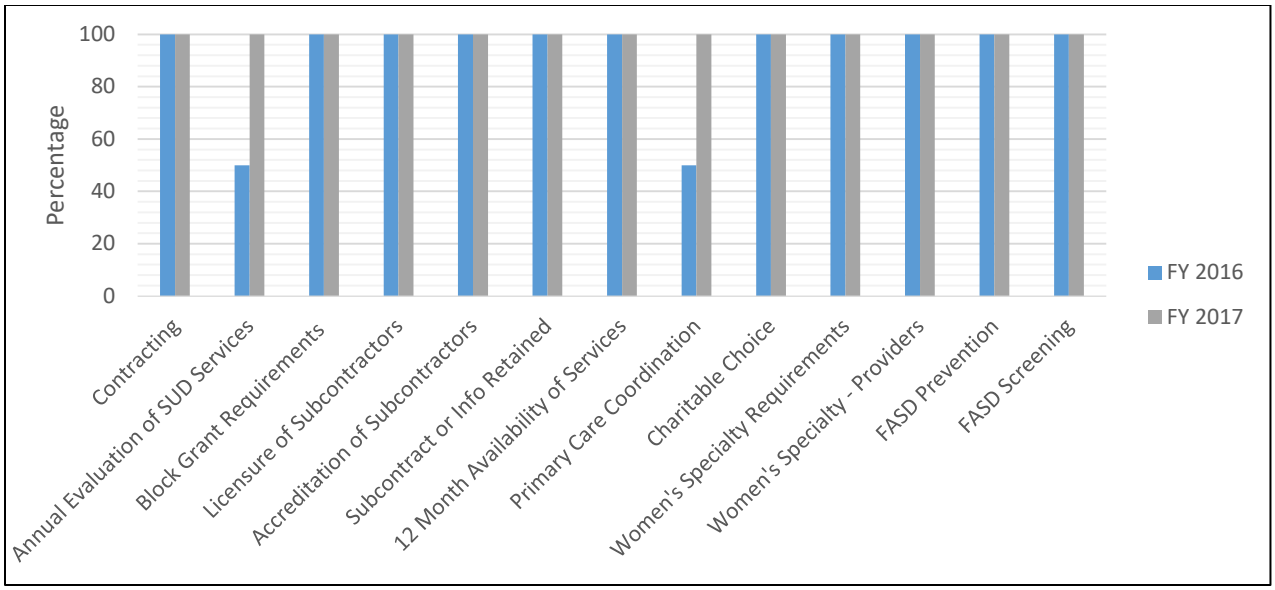
During FY2016, MSHN was determined to be in full compliance with eleven out of thirteen standards. MSHN was found to be in partial compliance with two standards and required to submit a plan of correction.

Summary of Findings (two elements):
(Scoring: 2 = Full Compliance (100%); 1 = Partial Compliance (50%); 0 = Non-Compliance (0%))

- Annual Evaluation of SUD Services: 100%
- Primary Care Coordination: 100%

Next Steps:
MSHN received a status of full compliance with all required plans of correction for FY2017. No further action is necessary at this time regarding the plans of correction. A full review by MDHHS of all standards will be completed for MSHN during FY2018.

Comparison of Results Full Review for FY2016 and Follow Up Review for FY2017:



MDHHS Autism Site Visit: May 23rd - May 24th

The Michigan Department of Health and Human Services completed the Autism ABA Site Review on May 23, 2017 through May 24, 2017. During the review MDHHS sampled and reviewed sixty-nine records for all required performance measures, including provider credentialing, in accordance with the Prepaid Inpatient Health Plan (PIHP) contract: General Statement of Work 7.0 Provider Network Services, attachment P 7.1.1, and Medicaid Provider Manual requirements outlined in, Behavioral Health & I/DD Chapter, Section 18 ABA.

Summary of Findings:

A. IPOS Addresses Needs
   a. There is a Comprehensive Individualized ABA Behavioral Treatment Plan: 94%
   b. Addresses Risk Factors: 92%
B. Services and Supports are Provided as Specified in the IPOS: 25%
C. Providers of the ABA Services meet Credentialing Standards: 1%
D. Ongoing Determination of Level of Service has Evidence of Measurable and Ongoing Improvement in Targeted Behaviors: 87%

Note: The percentages were calculated by dividing the total number of charts that received a score of "yes" (full compliance) by the total number of charts reviewed for all elements in each section.

Next Steps:

MSHN was required to submit a plan of correction for all standards that were determined out of compliance with the requirements.

This included providing the following:

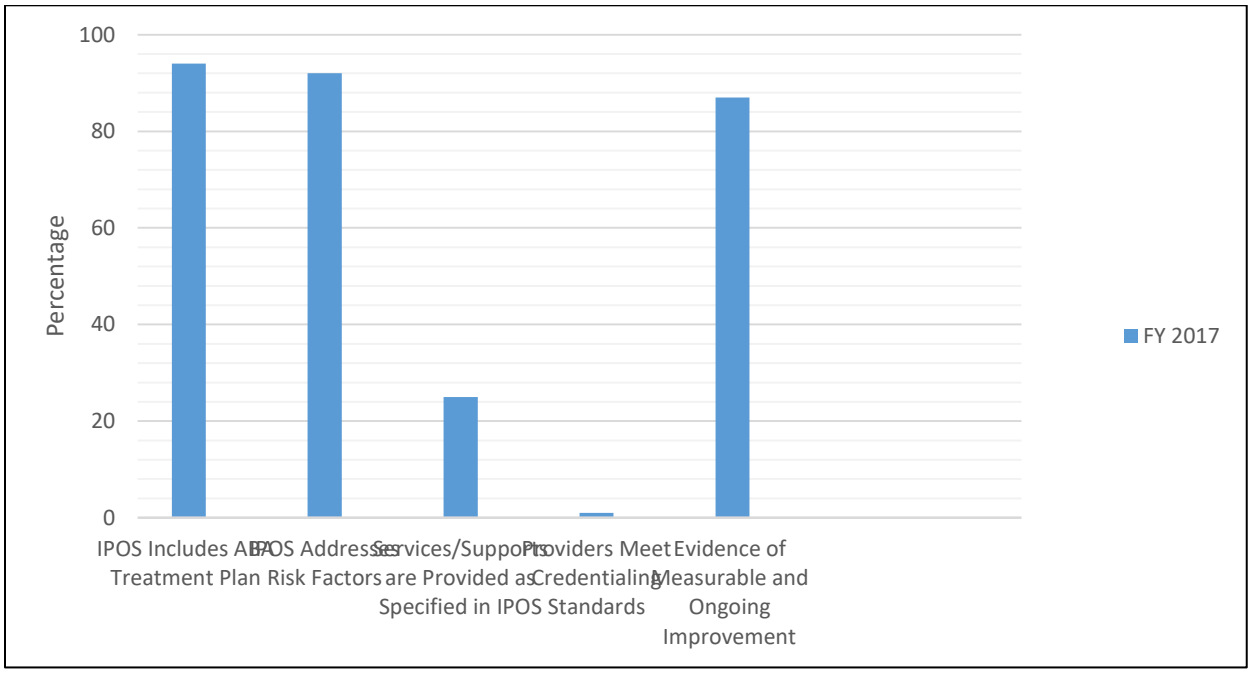
- Provide written policies and procedures to ensure:
  - The Individual Plans of Service address the needs of each beneficiary
  - That beneficiaries' amount, duration, and scope of ABA services are delivered in accordance with their individualized plan of service

    - Beneficiaries' ongoing determination of level of ABA service is occurring every six months in accordance with the policy requirements
- Provide written credentialing policies and procedures for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform autism ABA services within Michigan's Medicaid Program
- Ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual requirements
- Provide oversight regarding delegated credentialing or re-credentialing decisions
- PIHPs must ensure that an individual credentialing/re-credentialing file is maintained for each credentialed provider

The submitted plan of correction was approved by MDHHS and the effectiveness of the plans of correction will be reviewed during the next scheduled MDHHS site review.

Results Full Review for FY2017:

(No comparison was available as the last full review was completed in 2014 and the standards have changed)



MDHHS – Health Services Advisory Group (HSAG) – Performance Measurement Validation (PMV) Report: July 18th

Validation of performance measures is one of three mandatory external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA). State Medicaid agencies must ensure that performance measures reported by their managed care organizations (MCOs) are validated. Health Services Advisory Group, Inc. (HSAG), the EQRO for the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental

Disabilities Administration, conducted the validation activities for the prepaid inpatient health plans (PIHPs) that provided mental health and substance abuse services to Medicaid-eligible recipients.

HSAG completed MSHN's review onsite on July 18, 2017.

Data Collection and Analysis:
For this review, HSAG validated a set of performance indicators that were developed and selected by the Michigan Department of Health and Human Services (MDHHS). To conduct the on-site review, HSAG collected information using several methods including interviews, system demonstrations, review of data output files, primary source verification, observation of data processing and review of data reports.

Summary of Findings:

Performance Indicators (12 Elements): **100%**

Compliance was assessed through a review of the following:

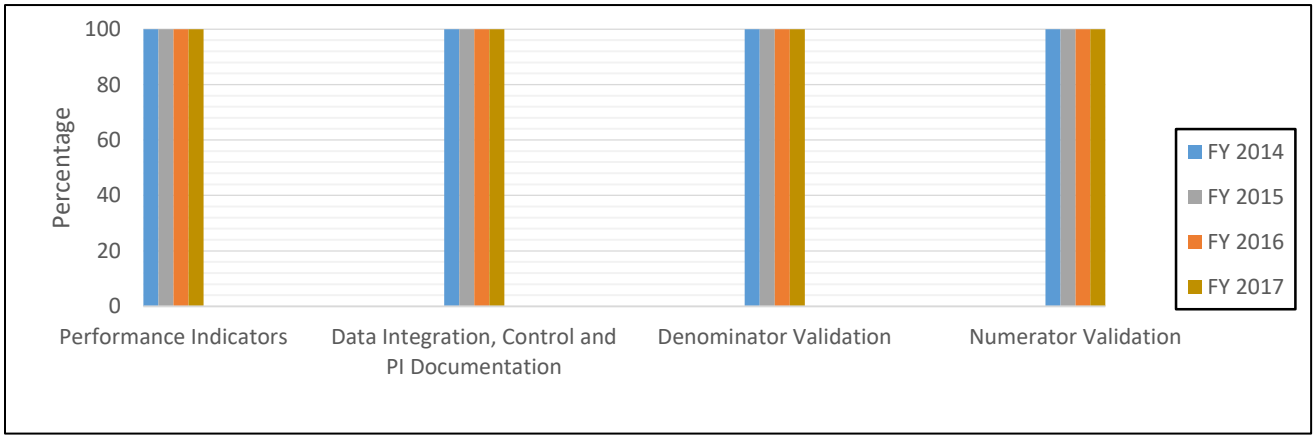
- Information Systems Capabilities Assessment Tool (ISCAT)
- Source Code (programming language) for performance indicators
- Performance Indicator reports
- Supporting documentation
- Evaluation of system compliance

Data Integration, Data Control and Performance Indicator Documentation (13 Elements): **100%**
Denominator Validation Findings (7 Elements): **100%**
Numerator Validation of Findings (5 Elements): **100%**

Strengths:
HSAG noted that MSHN maintained a solid team with years of relevant experience gained primarily through working for previous PIHPs. Staff members were very familiar with all processes related to performance indicator (PI) and BH-TEDS measures and data reporting requirements. The robust validation processes in place ensured that only complete and valid data were submitted to the State by the PIHP. As in the prior year, the PIHP demonstrated a strong commitment to the performance indicators and quality data reporting.

Next Step(s):
MSHN will continue to monitor performance and review areas for improvement. No corrective action is required to be submitted to HSAG for this review and HSAG did not identify any areas of improvement for MSHN.

Comparison of FY2014, FY2015, FY2016 and FY2017 Results:
(HSAG completes a full review each year for the PMV site review)



MDHHS- Health Services Advisory Group – Compliance Monitoring Review

The Health Services Advisory Group did not complete the Compliance Monitoring Review as part of this review cycle for FY2016/2017.

This review will be completed during FY2017/2018.

MDHHS – Health Services Advisory Group –Performance Improvement Project (PIP) Report: Validation Year 4: September 2017

MDHHS requires that the PIHP conduct and submit a Performance Improvement Project (PIP) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid consumers in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves. By assessing PIPs, HSAG assesses each PIHP's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients," according to the Code of Federal Regulations (CFR) at 42 CFR 438.364(a)(2).

The PIP study topic is: *"Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications."*

The FY2016-2017 PIP Summary Report analyzed the data for Remeasurement Two Period (October 1, 2015 – September 30, 2016) and reviewed the identified barriers, interventions and goals that were established by MSHN.

Summary of Results:

I. Select the Study Topic (2 Elements): 100%
II. Define the Study Question(s) (1 Element): 100%
III. Define the Study Population (1 Element): 100%
IV. Select the Study Indicator(s) (3 Elements): 100%
V. Use Sound Sampling Techniques (6 Elements): N/A for this study topic
VI. Reliably Collect Data (4 Elements): 100%

VII. Analyze Data and Interpret Study Results (8 Elements): 100%
VIII. Improvement Strategies (4 Elements): 100%
IX. Assess for Real Improvement (4 Elements): 100%
X. Assess for Sustained Improvement (1 Element): 100%

MSHN showed an increase from Remeasurement One Period to Remeasurement Two Period of 77.5% to 80.4%. This demonstrated a statistically significant improvement during the remeasurement period, exceeding the identified goal of 79% by 1.4 percentage points and showed an overall improvement of 6.7 percentage points above the baseline of 73.7%.

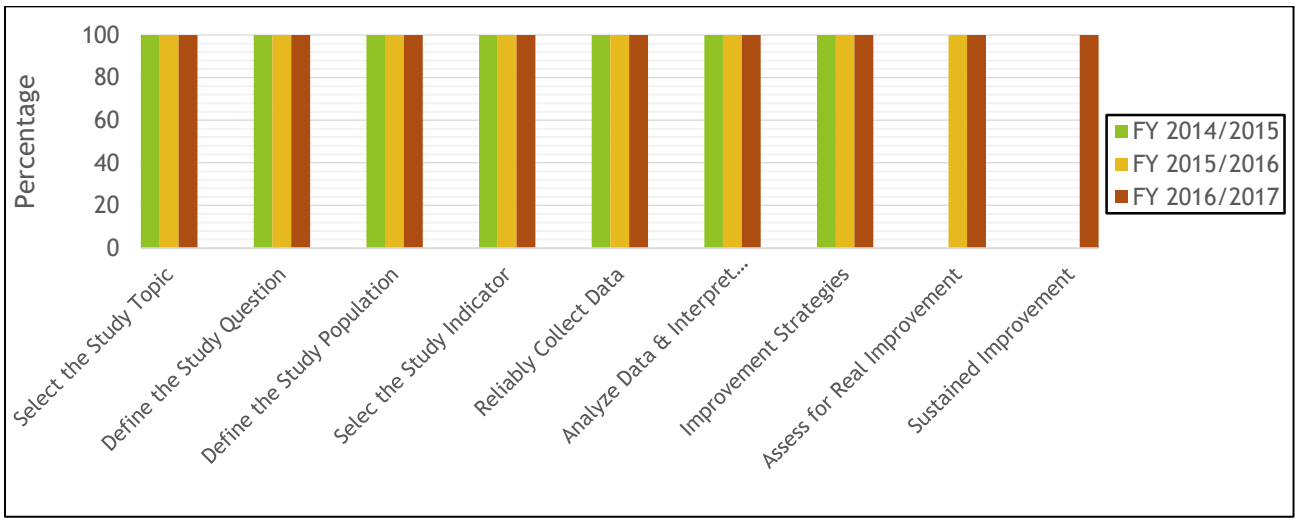
Strengths:

MSHN received a "Met" validation score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated. The performance suggests a thorough application of the PIP design, appropriate analysis of the results, implementation of system interventions that were related to barriers identified through quality improvement processes, and achievement of a statistically significant and sustained improvement in the study indicator rate over the baseline.

Next Steps:

MSHN is not required to submit a plan of correction for the PIP. MSHN will continue to utilize the Quality Improvement Council to complete a causal/barrier analysis at least annually and development appropriate interventions to address any new barriers.

Comparison of FY2014/2015, FY2015/2016 and FY2016/2017 Validation Results:
(HSAG completes a full review each year for the PIP)



Note: Assessment for Real Improvement was not measured during FY2014/2015

Note: Sustained Improvement was not measured during FY2014/2015 and FY2015/2016

SECTION FOUR – EVALUATION AND PRIORITIES

I. 2017 Annual Effectiveness Review of QAPIP Goals and Objectives

2017 QAPIP Annual Effectiveness Review					
	Objective	**Evaluation Method**	**Met, Partial, Unmet**	**Strategic Planning Objective**	**Council / Committee**
Components					
	Provide Oversight & Monitoring of the Provider Network	Implement Compliance Monitoring activities	Met	Enhance organizational quality & compliance	Quality Improvement Council
		Implement QAPIP	Met		Quality Improvement Council
	Guidance on Standards, Requirements & Regulations	Council & Committee review of MDHHS Contract and External Quality Review Requirements	Met		All Council & Committees
Governance					
	Board sets policy related to quality management	MSHN Quality Policies	Met	Enhance organizational quality & compliance	Board of Directors
	Board annually approves QAPIP & related priorities	Board approval of MSHN QAPIP	Met		Board of Directors
	QAPIP updated annually and reviewed by the QIC	Updated QAPIP and QIC approval	Met		Quality Improvement Council
Communication of Process and Outcomes					
	QIC monitors performance measurement activity	Performance Measure Reports	Met	Enhance organizational quality & compliance	Quality Improvement Council
	Identify opportunities for process and outcome improvements	Recommendations included in PM Reports	Met		All Council & Committees
	Require corrective action plans for measures below regulatory standards and/or targets	Corrective action plan submissions & reviews	Met		Quality Improvement Council
	Regular reports to Councils, Committees, Board of Directors and Advisory Councils	Council & Committee Annual Reports	Met		All Council & Committees
	Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	RCAC Reports on Consumer Satisfaction Survey Results, Recovery Survey Assessments, HEDIS Measure, MMBPIS, FUH, BTR, and Customer Service Reports	Met	Increase the voice of MSHN's customers and key stakeholder	Regional Consumer Advisory Council
	Board of Directors receive annual report on status of organizational performance	MSHN Scorecard, Annual QAPIP Effectiveness Review Report	Met	Enhance organizational quality & compliance	MSHN CEO

	Performance and Quality reports are made available to stakeholders and general public	MSHN website includes: QAPIP, Compliance Plan, MMBPIS, EQR Results, MDHHS review results	Met	Increase the voice of MSHN's customers and key stakeholder	MSHN Staff
Performance Measurement					
	Performance Indicators	MMBPIS Reports	Met	Improve Access to Care Assume increased responsibility for healthcare outcomes	Quality Improvement Council
	Performance Improvement Projects	PIP - RSA Report; PIP - HEDIS Report	Met		Quality Improvement Council
	Priority Measures	FUH Report, Diabetes Monitoring Report	Met		Quality Improvement Council
Event Monitoring and Reporting					
	Critical Incident Reporting to MDHHS	Critical Incident Performance Reports	Met	Assume increased responsibility for healthcare outcomes	Quality Improvement Council
	Trends and patterns identified	Critical Incident Reporting occurs on a quarterly basis to QIC; Trends & Patterns are identified and reviewed on a quarterly basis	Met		Quality Improvement Council
	Oversight of CMHSP risk analysis and reduction	On-site reviews completed at CMHSP's as part of DMC review in FY17	Met		Quality Improvement Council
Behavior Treatment					
	Quarterly analysis of adherence to BTR Standards	BTR Performance Reports	Met	Improved behavioral health treatment/service outcomes	Quality Improvement Council
	Trends and patterns identified	BTR Performance Reports includes patterns and related improvement recommendations	Met		Quality Improvement Council & Behavior Treatment Plan Review Workgroup
Autism Waiver Monitoring					
	Monitor compliance with Autism Benefit program requirements	Quarterly Autism Reports; FY17 on-site CMHSP DMC Program Specific Review	Partial	Improved access to care	Autism Workgroup
	Trends and patterns identified	Quarterly Autism Reports	Met		Autism Workgroup
	Oversight of CMHSP corrective action related to the MDHHS site review	Ongoing monitoring of corrective action plan responses and implementation outcomes	Met		Autism Workgroup
Quantitative and Qualitative Assessment of Member Experiences					
	Surveys analyzed	MHSIP & YSS Report, RAS and RSA reports, SUD summary report	Met	Improved behavioral health treatment/service outcomes	Quality Improvement Council

	Surveys shared with QIC and RCAC	MHSIP & YSS Report, RAS and RSA Reports, SUD Report shared with QIC and RCAC	Met	Increase the voice of MSHN's customers and key stakeholder	Quality Improvement Council & Regional Consumer Advisory Council
	Identified strengths and opportunities for improvement	FY16/17 completed regional surveys (MHSIP & YSS, RSA & RAS, and SUD); comparison to prior year data completed	Met	Improved behavioral health treatment/service outcomes	Quality Improvement Council & Regional Consumer Advisory Council
Practice Guidelines					
	CMHSP implementation of practice guidelines	Utilization Management Plan and Committee Report	Met	Improve access to care	Utilization Management Committee
		MSHN desk review verifications of local implementation; FY17 on-site reviews completed	Met	Improve access to care	Utilization Management Committee
Credentialing, Provider Qualification and Selection					
	Ensure CMHSP adherence to MSHN credentialing policy	Credentialing/Re-Credentialing policy has been developed in accordance with MDHHS contract requirements; FY17 on-site review completed;	Met	Enhance organizational quality & compliance	Provider Network Committee
Medicaid Event Verification					
	Verifies delivery of services billed to Medicaid	PIHP Medicaid Event Methodology Report	Met	Public resources are used efficiently and effectively	Quality Improvement Council
	Results aggregated, analyzed and reported at QIC	FY17 MEV Report completed and reviewed with QIC	Met		Quality Improvement Council
	Opportunities identified for improvement	FY17 MEV Report reviewed by; Discussion on improvements to the process and review of trends of non-compliance	Met		Quality Improvement Council
	Reported annually to MDHHS	FY17 MEV Report sent to MDHHS	Met		MSHN Deputy Director
Utilization Management Plan					
	UM Committee develops standards for utilization	Utilization Management Plan and Committee Report	Met	Public resources are used efficiently and effectively	Utilization Management Committee
	Utilization activity and trends are reviewed and analyzed	Utilization Management Plan and Committee Report	Met		Utilization Management Committee
	Uniform screening tools and admission criteria	Utilization Management Committee – LOCUS has been selected	Met	Improved behavioral health treatment/service outcomes	Utilization Management Committee

	Identification of under-and-over utilization	Utilization Management Reports	Partial	Public resources are used efficiently and effectively	Utilization Management Committee
Provider Monitoring					
	CMHSP annual monitoring of provider subcontractors	Annual Compliance Report Site review completed in FY17	Met	Enhance organizational quality & compliance	Quality Improvement Council & Provider Network Committee
	MSHN monitoring of CMHSPs and SUD Provider Network compliance	Annual Compliance Report; Site review completed in FY17	Met		Quality Improvement Council & Provider Network Committee
Oversight of "Vulnerable People"					
	CMHSPs monitor health, safety and welfare of individuals served	Annual DMC site reviews-clinical record reviews	Met	Assume increased responsibility for healthcare outcomes	Quality Improvement Council
	Related concerns are acknowledged and action taken as appropriate	Annual DCM site reviews- plans of correction	Met		Quality Improvement Council

II. MSHN FY17 Strategic Plan Priorities & Objectives

Focus	Objective/Strategies	Goal/Measurement	Target Date	Status
Better Health	***MSHN will improve its population and integrated health activities, and will develop a comprehensive integrated care/population health management plan***			
	SUD - Provider reports to MSHN/State (every 6 months)	1. MSHN will improve and standardize processes for exchange of data between MSHN and MHPs; CMHSPs and MSHN and will facilitate CMHSP-to-CMHSP data exchange	7/31/18	75% Complete
		2. MSHN will integrate SUD data with other behavioral health data at the PIHP level	12/31/17	75% Complete
		3. MSHN will establish the organizational capacity to process claims	2/01/18	75% Complete
	MSHN will develop and establish a measurement portfolio to improve use of data in monitoring regional performance metrics and assist with decision making, both internally and at the council, committee and board levels.	1. Continue deployment of the knowledge services improvement strategy to enhance use of data in all decision-making venues, including MSHN councils, committees and workgroups	Complete	Complete
		2. Health Information Exchange, including expanded number of use cases with MiHIN, occurs with other healthcare providers to assure appropriate integration and coordination of care	3/31/18	75% Complete
		3. Audited CMHSP participant records demonstrate evidence of primary care coordination (including consideration of CC360 information)	9/30/17	Complete
	MSHN will establish the organizational capacity to carry out its contractual responsibilities for improved care coordination with Michigan's Medicaid Health Plans	1. MSHN will establish a care coordination position on its staff to:	----------	----------
		a. Carry out MSHN obligations relating to care coordination and care coordination agreements with Medicaid Health Plans	Complete	Complete
		b. Provide assistance to CMHSP participants in complex care management/coordination	Complete	Complete
		c. Better integrate SUD with other behavioral health and physical health systems at the plan level	Complete	Complete
		2. MSHN will provide leadership in relation to care coordination activities with Medicaid Health Plans, including learning communities and clear role delineation	9/30/17	In Progress
		3. MSHN will engage with stakeholders, principally Medicaid Health Plans, to identify shared savings related to improved population health outcomes	7/1/17	Planning
		4. Medicaid Health Plans report satisfaction with MSHN's systems and collaboration to integrate and coordinate care	9/30/17	Planning
	Implement standardized assessment tools across the region for all populations served	1. Regionally implement the LOCUS system as contractually required	Complete	Complete
		2. Regionally implement a standardized SUD assessment tool.	Complete	Complete
		3. Regionally deploy the Supports Intensity Scale (SIS) and	9/30/17	Complete

		comply with related MDHHS contractual obligations		
		4. Develop systems to aggregate and report on regional performance in standardized assessments and outcomes reporting	5/31/17	Complete
	Implement required elements of the Home and Community-Based Service Final Rule with the goals of improved independence, community integration and freedom	1. internal capacity for the PIHP to carry out its responsibilities and to assist CMHSP participants with responsibilities for HCBS Implementation	3/31/17	Complete
		2. Develop and implement practice strategies for the MSHN provider network to comply with the new standards, including those related to onboarding new providers	6/30/17	In Progress
		3. Conduct fiscal impact analysis and incorporate into budgeting process	Complete	Complete
	MSHN implements a regional strategy to impact opioid-use disorders	1. MSHN develops strategies, with Medicaid Health Plans, to impact the prescribing of opioids	10/2017	Planning
		2. MSHN develops sustainable strategies to prevent accidental death through the distribution of Narcan	05/2017	75% Complete
	MSHN Operates Under a Comprehensive Integrated Care and/or Population Health Management Plan	1. MSHN Develops a Comprehensive Integrated Care and/or Population Health Management Plan	1/31/18	75% Complete
		2. Explore multi-PIHP collaboration to operate under a single mutl-regional Integrated Care and/or Population Health Management Plan	12/31/17	Complete
Better Care	***Improve Access to Care***			
	MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region	1. MSHN will work with hospitals, CMHSPs and the state to reduce inpatient denials and establish a more efficient system of ascertaining where inpatient vacancies exist	2/28/17	25% Complete
		2. All Healthy Michigan expended SUD services are regionally available	6/30/17	Waiting on Others
		3. All Medicaid and Healthy Michigan Specialty Behavioral Health Services described in the Medicaid Provider Manual are available through CMHSP direct-operated or contracted providers	Complete	Complete
		4. MSHN successfully negotiates regional inpatient contracts resulting in improved rates and performance results	6/30/17	75% Complete
		5. With its regional CMHSP participants, MSHN develops improved crisis and inpatient capacity for targeted acute care needs (related to CON Commission and Children/Youth Crisis Capacity Assessment)	6/30/17	In Progress
		6. MSHN will improve penetration of covered individuals in all eligibility categories, in part by defining a regional penetration rate analysis methodology that takes into consideration some of the uniqueness of the public behavioral health system	Complete	Complete
		7. Fully implement the region's access and authorization practice guidelines to achieve a common benefit	9/30/17	In Progress
		8. Standardize practices for documentation of medical necessity to assure people are receiving an appropriate scope, duration and intensity of care	9/30/17	Complete

		9. MSHN will ensure that the entire substance use disorder service array for Medicaid and Healthy Michigan Plan beneficiaries, described in the Medicaid Provider Manual, is available within 30 minutes/30 miles in urban counties or 60 minutes/60 miles in rural counties	Complete	Complete
		10. MSHN will ensure there are uniform access and utilization management criteria in place, and will monitor admissions and denials for conformity with the established criteria	3/31/17	75% Complete
	MSHN ensures expanded service access and utilization for ex-offenders through collaborative efforts with the MDOC, community corrections and other jail/prison stakeholders	1. Assess current state of service needs	9/30/17	Waiting on Others
		2. Define preferred partnerships and implementation approaches (specific planning with MDOC regarding SUD service access for persons with HMP)	9/30/17	Waiting on Others
		3. Monitor for increased access and service use (current national benchmark indicates that Michigan's incarcerated population is comprised of 20% of individuals in jails and 22% in prison with a serious mental illness; nationally the population ratio is 16% and 17%).	12/31/17	Waiting on Others
	Improve the Role of MSHN Customers and Key Stakeholders in MSHN Operations			
	Implement regional educational opportunities and input sessions around new initiatives and ongoing operational matters	1. Effectively implement improved trauma-informed practices through clearly defined learning communities	9/30/18	Not Started
		2. Establish regional opportunities for key stakeholder and provider input and communications	9/30/18	25% Complete
	Stakeholder feedback demonstrates effective, efficient and collaborative operations	1. Deploy a survey tool to measure participating provider satisfaction and achieve 80% satisfaction with the effectiveness and efficiency of MSHN's processes and communications	Complete	Complete
	MSHN will improve and integrate stakeholder and consumer input systems	1. Improve communication linkages between MSHN Regional Consumer Advisory Council and local councils	9/30/17	75% Complete
		2. Improve communication linkages between provider input forums, executive leadership and governance functions	9/30/18	In Progress
		3. Evaluate feasibility of survey consolidation and streamlining	9/30/17	Planning Stage
	Enhance Organizational Quality and Compliance			
	MSHN implements its approved Quality Assessment and Performance Improvement Plan (QAPIP), and specific Performance Improvement Plans, to improve quality and care across the region	1. Quality review tools are developed and implemented across the Substance Abuse Prevention and Treatment (SAPT) provider network	Complete	Complete
		2. The electronic health and managed care records for SAPT services are integrated with provider network management systems	9/30/17	In Progress
	MSHN will provide leadership on improving the consistency and implementation of person-centered planning in the region	1. MSHN will strengthen review of person-centered planning implementation in its provider network oversight activities	4/1/17	50% Complete
		2. MSHN will use data gathered in its provider network oversight activities to develop specific training and/or learning communities to strengthen person-centered	1/1/18	In Progress

		planning implementation		
Better Value	***Public Resources are Used Efficiently and Effectively***			
	Implementation of the region's utilization management (UM) plans demonstrate achievement of defined goals	1. MSHN has utilization patterns that are within expected statistical limits when benchmarked statewide and within the region	9/30/17	Complete
		2. MSHN adopts and implements site review protocol for utilization management (UM) reviews that are consistent with the regionally adopted UM plan	Complete	Complete
		3. Audited medical records demonstrate evidence of consistently applied medical necessity criteria, consistent with regionally approved criteria and sufficient to support scope, duration and intensity of services	Complete	Complete
	Regional Public Policy Leadership Supports Improved Health Outcomes and System Stability			
	MSHN Board of Directors reflect high degrees of satisfaction with MSHN operations and board development activities	1. Communications related to regional advocacy efforts result in board member satisfaction (improvements over prior year baselines)	Complete	Complete
		2. Board members report being informed of key funding actions and advocacy	Complete	Complete
		3. MSHN Board of Directors report strengthened advocacy efforts and skills	Complete	Complete
		4. MSHN leadership engages in planning and advocacy to provide system leadership and guide statewide planning	9/30/17	In Progress
		5. MSHN will explore ways of increasing the diversity of individuals serving on its boards, councils, committees and workgroups	4/1/17	Planning Stage
		6. MSHN will conduct a talent inventory of individuals serving on its board of directors to help guide talent acquisition as turnover occurs	5/30/17	In Progress
		7. MSHN will regularly report core metrics to the board of directors, ensuring standardization and use of rates to facilitate “apples-to-apples” comparisons	9/30/17	75% Complete
	MSHN develops and implements plan for PIHP accreditation	1. Select an accreditation provider	Complete	Complete
		2. Complete an accreditation readiness plan, including use of a consultant to guide readiness	Complete	Complete
		3. Implement necessary accreditation-related action plans regionally and within the PIHP	9/30/18	In Progress
		4. Achieve Accreditation	9/30/19	Not Started
	MSHN will ensure consistent, standardized, and cost-effective operations and will position the region for continued success regardless of payer structure	1. MSHN assists participating CMHSPs with cash flow requirements within the established rules and risk management plan	Complete	Complete
		2. MSHN will conduct feasibility and benefit/cost analyses in areas where efficiencies are likely to be gained	10/1/17	Not Started
		3. MSHN and its CMHSP participants fully implement the Statewide Reciprocity Policy within the region and between regions	9/30/17	25% Complete
		4. MSHN and its CMHSP participants will evaluate centralization of selected contracting functions	12/31/17	Planning Stage
		5. MSHN and its CMHSP participants will revisit the delegated managed care functions grid and update, and will consider conducting evaluations of the effectiveness and efficiency of delegating managed care functions	11/30/17	Planning Stage
		6. MSHN, with input from CMHSP participants, will consider	2/1/18	Not Started

		using a neutral third party to conduct cost-effectiveness evaluations and make recommendations for improvements		
		7. MSHN and its CMHSP participants will explore clinical process standardization, especially in the areas of access, emergency services, pre-admission screening, crisis response and inpatient stay management and discharge planning	Complete	Complete
	MSHN will expand capability to conduct fiscal planning and analysis	1. MSHN will work with CMHSP participants to develop uniform administrative costing processes	3/31/17	75% Complete
		2. MSHN will evaluate the financial and operational impact(s) of the HCBS Transition and develop appropriate plans	3/31/17	In Progress
		3. MSHN will evaluate the financial and operational impact(s) of the 1115 waiver and develop appropriate plans	3/31/17	In Progress
		4. MSHN will consider Value-Based Purchasing Pilot Programs in the SAPT provider system	12/31/16	In Progress
		5. MSHN will develop methodologies, within established rules, to incentivize providers to cooperate with the PIHP to improve health or other mutually agreeable outcomes.	12/31/16	In Progress
		6. MSHN will develop and implement a standardized Medical Loss Ratio (MLR) calculation (consistent with revised managed care rules)	Complete	Complete
		7. MSHN will implement and monitor the regional smoothing plan	Complete	Complete
	MSHN's Provider Network Management Systems are effective and efficient	1. MSHN is adequately staffed to accomplish its provider network oversight responsibilities	Complete	Complete
		2. MSHN publishes provider performance data to consumers and the public	9/30/18	Planning Stage
		3. MSHN develops inter-regional reciprocity systems	9/30/17	50% Complete
		4. MSHN will work with CMHSP participants to implement CCBHC-related systems, including Prospective Payment Systems	9/30/18	Not Started

III. QAPIP Priorities for Fiscal Year 2018 (Based on the FY17/FY18 MSHN Strategic Plan Priorities and

Objectives)

2018 QAPIP Priorities			
Priority	**Measure**	**Strategic Planning Objective**	**Assigned Council / Committee**
Better Health			
MSHN will develop and establish a measurement portfolio to improve use of data in monitoring regional performance metrics and assist with decision making, both internally and at the council, committee and board levels	1. Continue deployment of the knowledge services improvement strategy to enhance use of data in all decision-making venues, including MSHN councils, committees and workgroups	Improve Population and Integrated Health Activities	Quality Improvement Council & IT Council
Implement standardized assessment tools across the region for all populations served	1. Develop systems to aggregate and report on regional performance in standardized assessments and outcomes reporting.	Improved Behavioral Health Treatment/Service Outcomes	Quality Improvement Council & UM Committee
Better Care			
MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region.	1. All Medicaid and Healthy Michigan Specialty Behavioral Health Services described in the Medicaid Provider Manual are available through CMHSP direct-operated or contracted providers.	Improve Access to Care	Quality Improvement Council, Clinical Leadership Committee & UM Committee
	2. Fully implement the region's access and authorization practice guidelines to achieve a common benefit.		Quality Improvement Council & UM Committee
	3. Standardize practices for documentation of medical necessity to assure people are receiving an appropriate scope, duration and intensity of care.		Quality Improvement Council, Clinical Leadership Committee & UM Committee
	4. MSHN will ensure there are uniform access and utilization management criteria in place, and will monitor admissions and denials for conformity with the established criteria.		Quality Improvement Council
	5. Monitor compliance with Autism Benefit program requirements.		UM Committee
Better Care			
Implement regional educational opportunities and input sessions around new initiatives and ongoing operational matters	1. Establish regional opportunities for key stakeholder and provider input and communications	Improve the Role of MSHN Customers and Key	Quality Improvement Council

Stakeholder feedback demonstrates effective, efficient and collaborative operations	1. Deploy a survey tool to measure participating provider satisfaction and achieve 80% satisfaction with the effectiveness and efficiency of MSHN's processes and communications.	Stakeholders	Quality Improvement Council
MSHN will improve and integrate stakeholder and consumer input systems	1. Evaluate feasibility of survey consolidation and streamlining		Quality Improvement Council
MSHN implements its approved Quality Assessment and Performance Improvement Plan (QAPIP), and specific Performance Improvement Plans, to improve quality and care across the region	1. Quality review tools are developed and implemented across the Substance Abuse Prevention and Treatment (SAPT) provider network	Enhance Organizational Quality and Compliance	Quality Improvement Council, Clinical Leadership Committee, UM Committee & Provider Network Committee
MSHN will provide leadership on improving the consistency and implementation of person centered planning in the region	1. MSHN will strengthen review of person-centered planning implementation in its provider network oversight activities		Quality Improvement Council & Clinical Leadership Committee
Better Value			
Implementation of the region's utilization management (UM) plans demonstrate achievement of defined goals	1. MSHN adopts and implements site review protocol for utilization management (UM) reviews that are consistent with the regionally adopted UM plan.	Public Resources are Used Efficiently and Effectively	UM Committee
	2. Audited medical records demonstrate evidence of consistently applied medical necessity criteria, consistent with regionally approved criteria and sufficient to support scope, duration and intensity of services.		
MSHN develops and implements plan for PIHP accreditation	1. Implement necessary accreditation-related action plans regionally and within the PIHP.	Regional Public Policy Leadership Supports Improved Health Outcomes and System Stability	Quality Improvement Council
MSHN will ensure consistent, standardized, and cost-effective operations and will position the region for continued success regardless of payer structure	1. MSHN and its CMHSP participants will evaluate centralization of selected contracting functions.		Quality Improvement Council, IT Council & Provider Network
	2. MSHN and its CMHSP participants will revisit the delegated managed care functions grid and update, and will consider conducting evaluations of the effectiveness and efficiency of delegating managed care functions.		Quality Improvement Council

MSHN's Provider Network Management Systems are effective and efficient	1. MSHN publishes provider performance data to consumers and the public	Regional Public Policy Leadership Supports Improved Health Outcomes and System Stability	Quality Improvement Council & Provider Network

IV. MSHN Balanced Scorecard Report

MSHN FY17 - Board of Directors - Balanced Scorecard								
						Target Ranges		
Key Performance Areas	**Key Performance Indicators**	**Aligns with**	**Actual Value**	**Target Value**	**Performance Level**			
BETTER HEALTH	Complete SIS Assessments for adult persons with IDD	MSHN Strategic Plan FY17-FY18	79%	100%		>=75%	50%-74%	<50%
	Percent of providers who are in compliance with the HCBS Rule.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan	0.991	90%		>=76%	26%-75%	<=25%
	Child and adolescent access to primary care.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan; Measurement Portfolio Engaging Primary Care	96%	100%		>=75%	50%-74%	<50%
	Adult access to primary care.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan; Measurement Portfolio Engaging Primary Care	94%	100%		>=75%	50%-74%	<50%

	Increase use cases with MiHIN	Health Information Exchange		1	2			2	2	1
	ADHD medication follow up. This HEDIS measure reports the percentage of children newly prescribed ADHD medication who received at least three follow-up visits.	(Monthly) Aligns with strategic plan goal to establish clear criteria and practices that demonstrate improved primary care coordination and with Performance Measure Portfolio		Initiation: 72.77% ; C & M: 97.21% (Oct 2016 - Sep 2017)	Increase over FY 2016 (Initiation 73.8%; C & M 99.3%)			I:74% C&M: 99%	I:70% C&M:95%	I: 65% C&M: 91%
	Increased access to Women's Specialty Programs as reflected by increase by county of women receiving WSS compared to previous fiscal year (2016).	Aligns with MSHN SUD strategic plan goals to increase WSS (p.15)		1518 FY17 Oct-Sep	5% increase in women receiving WSS (FY16 1157)			Increase by 58+	20-57	<19
	Regional SUD and MH data integration	Health Information Exchange		0	1			1	0.75	0.25
BETTER CARE	Penetration rate by population shall increase 10% annually.	MSHN Strategic Plan FY17-FY18, MSHN UM Plan		0.0901	Improve over 2016			>=9.46%	9.45%-8.6%	<= 8.5%
	Percent of care coordination cases that were closed due to successful coordination.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan		50%	100%			>=50%	25%-49%	<25%

	Standard for Follow-up After Hospitalization for Adults with Mental Illness is met (FUH)	Measurement Portfolio NQF 0576		68%	58%				>=58%	0	<58%
	Standard for Follow-up After Hospitalization for Children with Mental Illness is met (FUH)	Measurement Portfolio NQF 0576		76%	70%				>=70%	0	<70%
	Address network capacity for detox services and medication assisted treatment, including availability of methadone, vivitrol and suboxone at all MAT locations	MSHN Strategic Plan FY17-18; Network Adequacy Assessment		7	6 over current				>6	3-4	<3
	Develop improved crisis and inpatient capacity for targeded acute care needs	MSHN Strategic Plan FY17-18; Network Adequacy Assessment		12% Increase	decrease 10%				>10%	7-9%	<6%
	The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (Plan All Cause Readmissions)	MSHN Strategic Plan FY17-FY18, MSHN UM Plan; Measurement Porfolio NQF 1768		8%	<=15%				<=15%	16-25%	>25%
BETTER VALUE	Define typical population service utilization patterns and methods of analysis to identify and recommend possible opportunities for remediation of over/under utilization.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan		1	100%				>=75%	50%-74%	<50%
	Reduction in number of visits to the emergency room.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan		0.5306	100%				>=75%	50%-74%	<50%

	Reduction in admits for psychiatric/physical health reasons.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan		0.73	100%				>=70%	45%-69%	<45%
	Develops a regional FI contract resulting in improved rates through standardizaiton	PNMC Annual Action Plan		85%	100%				>99%	83-99%	<82%
	MSHN reserves (savings & ISF)	Board of Directors Risk Management Target		9%	7.5%				≥ 7% and ≤ 8%	≥ 6.5% and < 7% or >8% and ≤ 8.5%	< 6.5% or > 8.5%
	MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget		83%	≥ 90%				≥ 90%	> 85% and < 90%	≤ 85% or >100%
	MSHN demonstrates performance within one standard deviation of statewide rates for 10 CPT/HCPCS codes as designated by Finance Council	MDHHS reported values		0.22	80%				≥80%	≥ 70% and ≤ 80%	≤60%

SECTION FIVE –DEFINITIONS

Community Mental Health Services Program (CMHSP): A program operated under Chapter 2 of the Michigan Mental Health Code - Act 258 of 1974 as amended.

CMHSP Participant: refers to one of the twelve member Community Mental Health Services Program (CMHSP) participant in the Mid-State Health Network.

Contractual Provider: refers to an individual or organization under contract with the MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP participants who hold retained functions contracts.

Customer: For MSHN purposes customer includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used within this definition: clients, recipients, enrollees, beneficiaries, consumers, primary consumer, secondary consumer, individuals, persons served, Medicaid Eligible.

MMBPIS: Michigan Mission Based Performance Indicator System

MSHN: Mid-State Health Network

MDHHS: Michigan Department of Health and Human Services

Prepaid Inpatient Health Plan (PIHP): In Michigan a PIHP is defined as an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care. (In Medicaid regulations, Part 438. Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package are now referred to as "PIHP" The PIHP also known as a Regional Entity under MHC 330.1204b also manages the Autism ISPA, Healthy Michigan, Substance Abuse Treatment and Prevention Block Grant and PA2. "

Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors.

Research: (as defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

Subcontractors: Refers to an individual or organization that is directly under contract with CMHSP and/or SRE to provide services and/or supports.

SUD Providers: Refers to Substance Use Disorder providers directly contracted with MSHN to provide SUD treatment and prevention services.